

05546

CERTIFICATE OF DEATH

05545

1. PLACE OF DEATH a. COUNTY <i>Prince Georges County</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. LENGTH OF STAY IN 1b <i>D. O. A.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges County</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges General Hospital</i>						d. STREET ADDRESS <i>4407 Tuckerman Street</i>					
3. NAME OF DECEASED (Type or print) First <i>Maurice</i> Middle <i>(mni)</i> Last <i>Alsop</i>						4. DATE OF DEATH Month <i>Apr.</i> Day <i>18</i> Year <i>1967</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 28, 1897</i>		9. AGE (In years lost birthday) yrs. <i>69</i>		10. IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>switchboard installer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>C &amp; P. Telephone Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Thaddens Alsop</i>						14. MOTHER'S MAIDEN NAME <i>Catherine Frank</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Andrey J. Alsop</i>		Address <i>4407 Tuckerman Street, Hyattsville, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Infarction</i> DUE TO (b) <i>Arterio-sclerotic Heart Disease</i> DUE TO (c) <i>Diabetes Mellitis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i> <i>6 yrs.</i> <i>8 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i></i> p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>38</i> to <i>Apr. 18</i> , 19 <i>67</i> (that (I) (we) last saw the deceased alive on <i>Apr. 17</i> , 19 <i>67</i> , and that death occurred at <i>12:45</i> M, from causes and on the date stated above.											
22a. SIGNATURE <i>Charles C. Hageage</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Apr. 19, 1967</i>			
22c. PHYSICIAN'S NAME <i>Charles C. Hageage M.D.</i>						22d. ADDRESS <i>3308 Perry St. Mt. Rainier, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 22, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Port Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>					
24. FUNERAL DIRECTOR <i>Clark E. Wisor</i>						ADDRESS <i>8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>APR 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05547

05546

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		c. LENGTH OF STAY IN 1b <b>6 Mo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regency Nursing Home</b>				d. STREET ADDRESS <b>7001 Marlboro Ritchie Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Cyrus Field Armiger</b>				4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1889</b>		9. AGE (In years last birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months <b>16</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John William Armiger</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Wayson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-16-7709</b>		17. INFORMANT <b>Roberta B. L. Plummer</b>		Address <b>Same as #2d</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Laceration of Wrist</b> DUE TO (c) <b>Mediastatic Carcinoma from Carcinoma of Lung.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Mediastatic Carcinoma from Carcinoma of Lung.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Cut Wrist with Knife</b>					
20c. TIME OF INJURY Month, Day, Year Hour, a.m. <b>10:30 PM</b> 3/2/67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Regency Nursing Home</b>		20f. (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>				22. DATE SIGNED <b>Apr 3, 1967</b>			
EXAMINER'S NAME (Type) <b>John Kehoe</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons, 300 4th St. NE Wash., D.C.</b>				25a. REC'D BY REGISTRAR <b>APR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



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VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

05548

05547

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sally Sarah S. Elizabeth Arnold</b>		4. DATE OF DEATH Month Day Year <b>April 3, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/99</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Tenna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Lee Hatcher</b>		14. MOTHER'S MAIDEN NAME <b>Leanah Richardson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William C. Arnold</b>		Address <b>Suitland Md. 4602 Chelsea Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 3, 1967</b> , to <b>April 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>10:35M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>April 4, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Alex. National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Alex. Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b> 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR <b>APR 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05549

CERTIFICATE OF DEATH

05548

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5906 Central Ave.</b> d. STREET ADDRESS <b>Capitol Heights</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Paul W Austin</b>		4. DATE OF DEATH Month Day Year <b>April 11 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 29 July 1929</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Envoy Motel</b>	9. AGE (In years last birthday) <b>37 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Newark, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank L. Austin</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude C. Auger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>WWII</b>	
17. INFORMANT <b>Mrs. Linda Lou Austin (above address)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease (Wife)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Multiple Thromboembolii - right lung</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(we)</del> attended the deceased from <b>Jan. 1965</b> , to <b>April 11, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>April 11, 1967</b> , and that death occurred on <b>April 11, 1967</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>April 12, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ohannes Sahakyan, M.D.</b>		22d. ADDRESS <b>Professional Bldg. Cheverly, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Carthage Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>California, Kentucky</b>	
24. FUNERAL DIRECTOR <b>Valley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>	
ADDRESS <b>Mt. Rainier Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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05550

## CERTIFICATE OF DEATH

05549

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>106 Bellgreen Street</b>				d. STREET ADDRESS <b>106 Bellgreen Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ESTHER</b>		First <b>M</b> Middle <b>BABCHAK</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 22, 1905</b>	
9. AGE (In years lost birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13. FATHER'S NAME <b>Robert Whited</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Duncan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Andrew J. Babchak</b> Address <b>106 Bellgreen Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 4200 DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4/30/67</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/26/67</b> to <b>4/30/67</b> that (I) (we) lost saw the deceased alive on <b>4/26/67</b> and that death occurred at <b>2:15 P.M.</b> from causes on and on the date stated above.							
22a. SIGNATURE <b>Dr. J. J. Donovan</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/30/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. J. Donovan</b>		22d. ADDRESS <b>1400 Hamp Rd</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-3-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road Suitland Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



0133

07220



CERTIFICATE OF DEATH

05550

05551

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 WKS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL (WASH DC 20021)</u>		d. STREET ADDRESS <u>5216 Colony Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RECENT NURSING HOME 7420 MARLBORO PIKE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>CHRISTINA</u> Last <u>Baier</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOLS</u>	9. AGE (In years last birthday) <u>78</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MARLAN, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN) NORGARD</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year of dates of service)		16. SOCIAL SECURITY NO. <u>504-09-9475A</u>	
17. INFORMANT <u>ROLAND V. BAIER</u>		Address <u>OXON HILL, MD 20021</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <u>3-14</u> , 19 <u>67</u> , to <u>4-1</u> , 19 <u>67</u> that (b) (we) just saw the deceased alive on <u>4-1</u> , 19 <u>67</u> , and that death occurred at <u>9:02</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W B Sheer</u>		22b. DATE SIGNED <u>4-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u>		22d. ADDRESS <u>6400 MARLBORO PIKE SE. WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>4-5-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE WOOD CEMETERY MINNEAPOLIS MINN</u>	23d. LOCATION (City or Town) (County) (State) <u>20021</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBER CO - Washington, DC</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05220

DEPARTMENT OF STATE

1222

APR 1 1981



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05551

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>6101 Kolb Street</b>	
3. NAME OF DECEASED (Type or print) <b>Samuel Thomas Bailey</b>		4. DATE OF DEATH <b>4 24 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-1888</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Wylie Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Dessie K. McCoy</b>		Address <b>Fairmont Hts 1118-60th Ave MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4200</b> (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>4-24-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>H-29-67</b>	23b. DATE THEREOF <b>4-29-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North Harmony</b>	23d. LOCATION (City or town) (County) (State) <b>Highland Park Md</b>
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Son 4925 Nime Ave NE</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



15250

5256



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

Items 10-21 Film #391  
0-9-87 mt  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05553

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05552

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>3151 Queens Chapel Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ann Elizabeth Barnes</b>		4. DATE OF DEATH Month Day Year <b>4 21 19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-23</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Mercia</b>		14. MOTHER'S MAIDEN NAME <b>Florence</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>227 18 0037</b>	
17. INFORMANT <b>Raymond H. Barnes</b>		Address <b>Same as #2 (husband)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Acute barbiturate intoxication</b> DUE TO (c) <b>9702</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingested overdose of barbiturates</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>4 21</b> p.m. <b>19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Mt. Rainier Pr. Geo Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		M.D.	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		22. DATE SIGNED <b>4-22-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



0220

5224



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

05554

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05553

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4703 41st Street</b> 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>Hyattsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Kenneth</b> First Middle Last			4. DATE OF DEATH <b>4</b> Month <b>29</b> Day <b>1967</b> Year		
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-12</b>		9. AGE (In years last birthday) yrs. <b>54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRASH COLLECTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>HOWARD BARNES</b>			14. MOTHER'S MAIDEN NAME <b>LOUISE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Mrs. LOUISE BARNES</b> Address <b>4703 41st St. HYATTSVILLE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute subdural hematoma, right frontal lobe.</b> DUE TO (b) <b>Laceration of right frontal lobe.</b> DUE TO (c) <b>Skull fracture, right posterior fossa.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fell and struck head on stone floor</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>6:00pm</b> <b>4-26-67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4710 41st Place, Hyattsville, P.G., Md.</b>	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>4-30-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-3-67</b>		23b. DATE THEREOF <b>5-3-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>	
		23d. LOCATION (City or Town) (County) (State) <b>Prince George's County</b>			
24. FUNERAL DIRECTOR <b>John T. Rhine's</b>		ADDRESS <b>3015 - 12th St., N.E.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



05253

05253

TRASH COLLECTION

CLARK JAMES

LOUIS

MR. LOUIS JAMES

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1000

HATTIESBURG, MS.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05554

FOR STATE  
HEALTH DEPT

05555

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bladensburg Motel</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothy Gail Baur</b>		4. DATE OF DEATH <b>4 4 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-29-1945</b>
9. AGE (In years lost birthday) yrs. <b>21</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>16 1</b>	
11. BIRTHPLACE (State or foreign country) <b>PENN'A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>R. RUSSELL</b>		14. MOTHER'S MAIDEN NAME <b>AUDREY TAMBLIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>GERALD BAUR</b>		Address <b>5401 JOAN LAKE TEMPLE HILLS MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barbiturate intoxication</b> 970.2 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Took overdose of barbiturates.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>PM 4-2- 19 67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bladensburg Motel, Bladensburg, Md.</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>4-4-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-8-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. VERNON - CEM.</b>	23d. LOCATION (City or town) (County) (State) <b>VERSAILES, PENN'A.</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

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VR A15 (4)  
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05556

CERTIFICATE OF DEATH

05555

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>50 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>3717 35th St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Vera P. Beacraft</b>			4. DATE OF DEATH Month Day Year <b>April 18 1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 Aug., 1930</b>		9. AGE (In years lost birthday) yrs. <b>36</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>	
13. FATHER'S NAME <b>John Clendening</b>			14. MOTHER'S MAIDEN NAME <b>Vera P Harrison</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 38 4431</b>		17. INFORMANT <b>Sandra L. Bennett</b> <b>9445 Arlington Bl'vd. Fairfax, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cirrhosis of Liver</b> DUE TO (c) <b>Chronic Alcoholism</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Feb. 27,</b> 1967, to <b>April 18,</b> 1967, that <del>we</del> (we) lost saw the deceased alive on <b>April 18,</b> 1967, and that death occurred at <b>12:45 AM</b> from causes on and on the date stated above.					
22a. SIGNATURE <b>B. Bahrami, M.D.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. Bahrami, M.D.</b>		22d. ADDRESS <b>Prince Georges general Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, P. G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05556

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b> 16.1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>5286 Marlboro Pike</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Benjamin Bernard Bean</b>				4. DATE OF DEATH Month Day Year <b>4 9 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 Nov. 1900</b>	9. AGE (In years lost birthday) yrs. <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTING</b>		11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BENJAMIN A. BEAN</b>				14. MOTHER'S MAIDEN NAME <b>EVA RICHARDSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WWI</b>		16. SOCIAL SECURITY NO. <b>577-07-5760</b>		17. INFORMANT Address <b>ANNA C. BEAN</b> See # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 5 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes - over 1 yr., Gout - over 3 years.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.				22. DATE SIGNED <b>4-10-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				Address (Street, city, town, or county)			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria Nat'l Alexandria, VA</b>		23d. LOCATION (City or town) (County) (State) <b>Alexandria, VA</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers 5711 1/2 St SE</b>				25a. REC'D BY REGISTRAR <b>APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05557

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN Tb <b>3 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		d. STREET ADDRESS <b>4706 Tecumseh Street</b>	
3. NAME OF DECEASED (Type or print) <b>Ellen</b> First <b>Ida M.</b> Middle <b>Behrens</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 11, 1912</b>
9. AGE (In years last birthday) yrs. <b>54</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Burton C. Millard</b>		14. MOTHER'S MAIDEN NAME <b>Della Edna Wademan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212 05 0560</b>	
17. INFORMANT <b>Walter G. Behrens</b>		Address <b>Same as #2 (husband)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma breast &amp; metastasis</b> DUE TO <b>to ribs, spine &amp; pelvis</b> (b) <b>Bones</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19 <b>Apr 27</b> to <b>Apr 28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Apr 27</b> , 19 <b>67</b> , and that death occurred at <b>8 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Walcott Etienne</b>		22b. DATE SIGNED <b>4/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walcott Etienne, M. D.</b>		22d. ADDRESS <b>4713 Berwyn Rd. College Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>	23d. LOCATION (City or Town) (County) (State) <b>Hyattsville P. G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	







FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #7 Film #G387 4/18/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05553

05558

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deanwood Park</b>	
c. LENGTH OF STAY IN lb <b>DOA</b>		d. STREET ADDRESS <b>1325 Eastern Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Luella</b>		4. DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <b>6 Oct. 1910</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Marion Belford</b>		14. MOTHER'S MAIDEN NAME <b>Alvernie Whitlock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mamie Sargent, Bunker Hill, W. Va</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-1-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-9-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Gore, Frederick, Virginia</b>	
24. FUNERAL DIRECTOR <b>John P. Clark</b>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	
ADDRESS <b>Hagerstown, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05559

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Short Cut Rd. Rt. 301.</b>	
3. NAME OF DECEASED (Type or print) <b>Burtis</b>		4. DATE OF DEATH Month <b>4</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Jan. 1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GAS STATION</b>	9. AGE (In years la. birthday) yrs. <b>51</b>
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS BEVERLIN</b>		14. MOTHER'S MAIDEN NAME <b>VICTORIA BONNELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WWII</b>		16. SOCIAL SECURITY NO. <b>INFORMANT Peggy Adams 1014 Strauss Ave. Indian Head, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intoxication (carbon monoxide)</b> DUE TO <b>And asphyxiation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>From inhalation of smoke.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>9160</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Inhaled smoke while asleep during fire in house trailer.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4:10am</b> p.m. <b>4-14-1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>4-14-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pisgah Methodist Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Pisgah, Chas. Md.</b>
24. FUNERAL DIRECTOR <b>The Hunt Funeral Home, Stalder, Md.</b>		25. REC'D BY REGISTRAR <b>APR 20 1967</b>	
25a. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05561 CERTIFICATE OF DEATH 05560

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>				c. LENGTH OF STAY IN 1b <b>63 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6425 ALLEN TOWN ROAD</b>				d. STREET ADDRESS <b>6425 ALLEN TOWN RD.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH LOUISE BIGGS</b>				4. DATE OF DEATH Month Day Year <b>APRIL 9 1967</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 12, 1886</b>	
				9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASH. D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>HENRY SROUTH</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>1231</b>		17. INFORMANT <b>JULIA E. DORE</b> Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 1231 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebrovascular accident</b> 36 hrs DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b> 20 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>None</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) (County) (State) <b>None</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 19, 1962</b> to <b>Present</b> , that (I) (we) last saw the deceased alive on <b>APRIL 7, 1967</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Arthur Shaver Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 9, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR.</b>				22d. ADDRESS <b>8808 Beaulieu Ave. Clinton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 12-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b> ADDRESS <b>1661-Good Hope Rd., SE Wash DC</b>				25a. REC'D BY REGISTRAR <b>ARR 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



05500

05500





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS</b> c. LENGTH OF STAY IN 1b <b>26 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>BOLLING AIR FORCE BASE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>11-3</b> d. STREET ADDRESS <b>QTRS 65</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>PERCY</b> Middle <b>P</b> Last <b>BISHOP</b>						4. DATE OF DEATH Month <b>8</b> Day <b>APRIL</b> Year <b>19 67</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 MAY 1877</b>		9. AGE (in years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>11</b> Hours <b>3</b> Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>TENNESSEE (CONTY UNK)</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOHN McELROY BISHOP</b>						14. MOTHER'S MAIDEN NAME <b>MARGARET WOOD</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>RET 1941</b>				16. SOCIAL SECURITY NO. <b>004-46-08-44</b>		17. INFORMANT Address <b>GEN DONNELLY Son in law, same as #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCT</b> <b>493 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>PNEUMONIA</b> DUE TO (c) <b>CHRONIC DIABILITATION</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 Weeks</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. DATE AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>13 MAR</b> , 19 <b>67</b> , to <b>8 APR</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8 APRIL</b> , 19 <b>67</b> , and that death occurred at <b>1145</b> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b>						M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>8 APR 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>RUBEN ALTMAN, CAPT, USAF, MC</b>						22d. ADDRESS <b>WASH, D.C. 20331</b> <b>USAF HOSPITAL ANDREWS, ANDREWS AFB</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>4/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL.</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON VA</b>			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO. INC. WASH. D.C.</b>						25a. REC'D BY REGISTRAR <b>DA APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



05581

05581

PRIME POWER

20 DAYS HOLDING AIR FORCE BASE

USAF HOSPITAL ALABAMA

TEROY

ALBINO

27 MAY 1973

WAS

U.S. ARMY

OFFICER

JOHN MCELROY BISHOP

MARGARET WOOD

APR 1971

UNIT 11-22-24

ACUTE MYOCARDIAL INFARCT

ENDOTRACHEAL INTUBATION

07 APR 71

13 MAY

07

07 APR 71

ROBERT ALTMAN, CAPT, USAF, MCUSAF HOSPITAL, ANDREWS AFB, MD

APR 12 1971



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05563

CERTIFICATE OF DEATH

05562

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>17-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN lb <b>1 mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1435 Shepherd St., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Cora L. Blalock</b>		4. DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/1878</b>
9. AGE (In years last birthday) yrs. <b>88</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>12</b> <b>12</b> <b>1967</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Miss.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ? Gardner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>428-03-4345</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus; generalized arteriosclerosis; old cerebrovascular accident.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>3/10/1967</b> , to <b>4/12/1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>4/12/1967</b> , and that death occurred at <b>7:30PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>4/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-17-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND MARYLAND</b>
24. FUNERAL DIRECTOR <b>W. ERNEST HARVIS CO.</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>	
ADDRESS <b>1432 Yew St. N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	



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Prince George

(1971) 1000

Journal of the American Medical Association

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674

Albert Garner

2012-01-03

ВВЕДЕНИЕ

D. A. Wells, A. D.

1990

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05564

## CERTIFICATE OF DEATH

05563

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>309 Lexington Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Gardiner</u> Last <u>Blanche</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1907</u>
9. AGE (In years last birthday) yrs. <u>59</u>		10. IF UNDER 1 YEAR Months <u>15</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stonemason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Geo. Fuller Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Blanche</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Neilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>214-03-8576</u>	
17. INFORMANT <u>Helen Blanche</u>		Address <u>309 Lexington Drive</u> <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion (Stroke)</u> DUE TO " " " " " " Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) " " " " " " (c) " " " " " "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/9/67</u> , 19 <u>67</u> , to <u>4/29/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/9/67</u> , and that death occurred at <u>12:04</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Howard I. Morse</u>		22b. DATE SIGNED <u>4/29/67</u>	
22c. PHYSICIAN'S NAME <u>Howard I. Morse M.D.</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by the State - Prince Georges County



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DEPARTMENT OF DEATH

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb. <b>1hr. 13 min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>939 Parkhill Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Francis Blankenship</b>		4. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-1943</b>
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Alum. Siding Installer Home Improvement</b>		11. BIRTHPLACE (State or foreign country) <b>Laurel, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANCIS BLANKENSHIP</b>	
14. MOTHER'S MAIDEN NAME <b>LAURA C. RIDER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>219-40-1681</b>		17. INFORMATION <b>201 Washington St., Savage, Maryland</b> <b>Mrs. Linda McClure, - Sister</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of abdomen</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>981X</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot during altercation.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>8:44pm</b> m.m. <b>4-30-1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>330 Prince George St., Laurel, Md.</b>	
20f. (City or town) (County) (State) <b>Laurel, Maryland</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>5-1-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>	23b. DATE THEREOF <b>May 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Laurel, Maryland</b>
24. FUNERAL DIRECTOR <b>Harold S. Wade, Laurel, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05567 CERTIFICATE OF DEATH 05566

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>NORTH CAROLINA</b> COUNTY <b>BERTIE</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SEAT Pleasant</b>		c. LENGTH OF STAY IN 1b <b>12 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7203 BOOKER DRIVE</b>		d. STREET ADDRESS <b>WILLIAMSTON</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>MAE</b> Last <b>BOND</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-1878</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNOER 1 YEAR IF UNOER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WINDSOR NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CULLEN SPELLER</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-18-778</b>	
17. INFORMANT <b>DAUGHTER</b>		Address <b>MARGARET MOUNTAIN 7203 BOOKER DR. SEAT Pleasant</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341 INANITION</b> DUE TO (b) <b>CONGESTIVE HEART FAILURE</b> CAUSE (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC GASTRITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>3 WEEKS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-11, 1964</b> to <b>4-25, 1967</b> , that (I) (we) last saw the deceased alive on <b>4-25, 1967</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles W. Coleman M.D.</b>		22b. DATE SIGNED <b>4-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Coleman</b>		22d. ADDRESS <b>7220 BOOKER DR. SEAT Pleasant</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-29-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>COLEMAN</b>		23d. LOCATION (City, town or county) (State) <b>GUM SPRINGS, VA.</b>	
24. FUNERAL DIRECTOR <b>ROLLINS FUN. HOME INC.</b>		ADDRESS <b>4339 HUNT PL., NE</b>	
25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03568					CERTIFICATE OF DEATH			05567	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 3708 35th Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henrietta E Bond					4. DATE OF DEATH Month Day Year April 26 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Oct., 1891		9. AGE (In years last birthday) yrs. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk- Peoples Drug Store			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oliver L. Bond					14. MOTHER'S MAIDEN NAME Minnie Lerp				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Miss Ruth Olive Bond same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 5810 DUE TO Cirrhosis of the Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>(the hospital)</del> attended the deceased from April 17, 1967, to April 26, 1967, that (I) <del>(we)</del> last saw the deceased alive on April 26, 1967, and that death occurred on April 26, 1967, at 5:15 PM from causes and on the date stated above.									
22a. SIGNATURE Benjamin S. Miller					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4-27-67	
22c. PHYSICIAN'S NAME (Type) Benjamin S. Miller, M. D.					22d. ADDRESS 3824 - 34th St., Mr. Rainier, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.		
24. FUNERAL DIRECTOR The S. H. King Co. Wash, D.C.					25a. REC'D BY REGISTRAR DATE MAY 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05569					05568				
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u> <u>3704 - 40th PL.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COTTAGE CITY</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COTTAGE CITY</u>			16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3704 - 40th PLACE</u>					d. STREET ADDRESS <u>3704 - 40th PLACE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>JOHN</u> Middle <u>MINOR</u> Last <u>BOTTS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1967</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 14, 1876</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUSINESS AGENT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>STEAM FITTERS UNION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13. FATHER'S NAME <u>THOMAS BOTTS</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA HASLIP</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>			16. SOCIAL SECURITY NO. <u>578 036148</u>		17. INFORMANT Address <u>ELLSWORTH N. BOTTS 6628 23 PL LEWISDALE, MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis, arteriosclerotic heart disease</u> (c) <u>disease</u> DUE TO (a) (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>52</u> , to <u>4/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> , 19 <u>67</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Earl W. Graeff</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-10-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF, M.D.</u>				22d. ADDRESS <u>2716 Kirkwood Pl., W. Hyattsville, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-14-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		23d. LOCATION (City, town or county) (State) <u>BLADENSBURG, MARYLAND</u>			
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co - RICKETTS, MD.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>APR 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



02208

02208

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United States

Department of the Interior

Washington

April 1, 1961

21

Mr. [illegible]

Dear Sir:

Enclosed for you are 21 copies of the report of the

APR 1 1961



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #13 infor, taken from birth cert.

05570

## CERTIFICATE OF DEATH

05569

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN lb <b>3 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>RFD # 3914</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Bowman</b>	4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1967</b>
9. AGE (In years last birthday) yrs. <b>3</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ellis Stanley Bowman</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Anita Griffith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>751X</b> IMMEDIATE CAUSE (a) <b>Heart type congenital abnormalities</b> DUE TO (b) <b>(Hydrocephalus, Cleft palate, Cardiac murmur,</b> DUE TO (c) <b>Imperforate anus)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 12, 1967</b> , to <b>April 15, 1967</b> , that (I) (we) saw the deceased alive on <b>April 15, 1967</b> , and that death occurred at <b>3:15 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. Clark Holmes</b>		22b. DATE SIGNED <b>4/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M.D.</b>		22d. ADDRESS <b>4108 Pratt St., Upper Marlboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>4/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hosp</b>	23d. LOCATION (City or Town) (County) (State) <b>Cheverly PG Maryland</b>
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Admin., Cheverly, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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## CERTIFICATE OF DEATH

05570

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>6906 B Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>D.</b> Last <b>Boyer</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/11</b>
9. AGE (In years last birthday) yrs. <b>55</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEAMFITER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John E. Boyer</b>	
14. MOTHER'S MAIDEN NAME <b>Pamela Dunlap</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Donald D. Boyer 3400 Brinkley Rd. Oxon Hill</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , 19 <b>7</b> to <b>4/7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/6</b> , 19 <b>67</b> , and that death occurred at <b>7:25 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Peter Duus</i>		22b. DATE SIGNED <b>4/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Peter Duus</b>		22d. ADDRESS <b>6124 Central Ave., Capitol Hgts. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Charles Town, West Virginia</b>
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>		25. RECEIVED BY REGISTRAR <b>APR 11 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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CONTINUATION OF FORM

DATE

APR 11 1985



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the filer. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05572

05571

1. PLACE OF DEATH e. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>WASH. DC.</u> b. COUNTY <u>11-3</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESVERLY</u>		c. LENGTH OF STAY IN lb <u>D.O.A</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>		d. STREET ADDRESS <u>2824 DEVONSHIRE PL. NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGES GEN. HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE VINCENT BRENNEMAN</u>				4. DATE OF DEATH Month Day Year <u>APRIL 5, 1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JULY 4, 1893</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE &amp; INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELI BRENNEMAN</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA MARKLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-28-7093</u>		17. INFORMANT Address <u>GEORGE V. BRENNEMAN, JR 4014 SUMMIT DR KENILWORTH MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8254</u> DUE TO <u>Wounds Multiple Stab</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Severe Fracture chest.</u> (c) <u>Skull Crushing injury abdo &amp; chest</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Acclosure of Circumflex Branch of L</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Coronary artery disease</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>auto accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>6:30</u> a.m. <u>april 5</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Roadway on Md Del</u>		20f. (City or town) (County) (State) <u>Pr Geo Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dayton Watkins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-7-67</u>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Rt 665 Rte 200 R. Gen Co. MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/8/1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>Rt 665 Rte 200 R. Gen Co. MD</u>	
23. FUNERAL DIRECTOR <u>W. W. CHAMBERS, INC</u>				ADDRESS <u>5127 Spring</u>		24a. REC'D BY REGISTRAR <u>APR 11 1967</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05573

05572

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cnevelly		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4315 Oglethorpe Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary H. Brewer		4. DATE OF DEATH Month Day Year April 1, 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1875	
9. AGE (In years and birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Editorial Dept		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Samuel Blount Brewer		14. MOTHER'S MAIDEN NAME Marian MacFarlane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 60 5195 I	
17. INFORMANT Miss Virginia W. Brewer (niece)		Address: Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Myocardial Infarct (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 3-29-67 4-1-67			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 15, 1966, to April 1, 1967, that (I) (we) saw the deceased alive on 4-1-67, and that death occurred at 3:10 P.M., from causes and on the date stated above.			
22a. SIGNATURE De Deitz		22b. DATE SIGNED 4-2-67	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz		22d. ADDRESS Prince George Plaza Hyattsville, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 4/5/67	
23c. NAME OF CEMETERY OR CREMATORY Hillside		23d. LOCATION (City or Town) (County) (State) Anniston Alabama	
24. FUNERAL DIRECTOR Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE APR 4 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



05235

05235

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535  
MAY 11 1968  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-157341)  
SUBJECT: [illegible]  
RE: [illegible]

[illegible handwritten notes and stamps]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05574

Item 9 Film 0387 1/11/67 KK

CERTIFICATE OF DEATH

05573

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TB <b>1 hr 10 mins</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Hgts</b> d. STREET ADDRESS <b>709-62nd Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>I.</b> Last <b>Brooks</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/17/15</b>
9. AGE (In years last birthday) <b>52 5</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, .DC.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Eli Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Pinkney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John Brooks</b>		Address <b>Kentland, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cama</b> DUE TO <b>331X Cardiovascular Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 3, 1967</b> , to <b>April 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>10:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/7/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>John H. Stewart</b>		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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Prince Georges General Hospital

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John Brooks-7316 73rd Ct. Maryland

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Prince Georges

Prince Georges General Hospital



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05575

CERTIFICATE OF DEATH

05574

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-1															
c. LENGTH OF STAY IN 1b <u>At 1 1/2 Hours</u>				d. STREET ADDRESS <u>3134 Nicholson Pl</u>															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>Mrs. CLARA</u> Middle <u>L.</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1967</u>															
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 24, 1886</u>		9. AGE (in years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Mln.		IF UNDER 24 HRS. Mln.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>				11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Randolph A. Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Jackson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Andrew J. Brown - 5009 40th Pl. Hyattsville MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary atherosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>4-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-3</u> , 19 <u>67</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>Donald C. Edgren</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Apr. 3, 1967</u>											
22c. PHYSICIAN'S NAME (Type) <u>DONALD C. EDGREN</u>				22d. ADDRESS <u>Hyattsville, Md.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>April 6, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Suitland, Baltimore Md</u>							
24. FUNERAL DIRECTOR <u>Arthur Walters</u>				ADDRESS <u>254 Carroll St NW. DC</u>				25a. REC'D BY REGISTRAR <u>APR 7 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>							



02575

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05576

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05575

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>Box 55</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Isaac Brown</b>				4. DATE OF DEATH Month <b>4</b> Day <b>10</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 Dec. 1913</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Brown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>W.W. 2</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William Brown Crownsville, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>				22. DATE SIGNED <b>4-11-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4-14-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Natl.</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>William Beesett, Annapolis</b>				25a. REC'D BY REGISTRAR <b>APR 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05577

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05576

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 hrs. 20 min.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5102 Lafayette Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles K. Buler</b>		4. DATE OF DEATH Month <b>4</b> Day <b>20</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-1918</b>		9. AGE (In years lost birthday) yrs. <b>48</b>
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Conn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Edward O. Buler</b>		14. MOTHER'S MAIDEN NAME <b>Margaret A. Shannon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>139 16 1644</b>		17. INFORMANT <b>Rosemary Buler Same as #2 (wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>And Right hemothorax from multiple rib fractures</b> (b) <b>And right pneumothorax from laceration of lung.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car which ran off road and hit guard rail.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9:10pm</b> m. <b>4-19-1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3800 block Kenilworth Ave., Bladensburg, Md.</b>	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-21-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria National</b>	
23d. LOCATION (City or Town) (County) (State) <b>Alexandria Va.</b>					
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05578

CERTIFICATE OF DEATH

05578

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		c. LENGTH OF STAY IN 1b <b>16 1/2</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		d. STREET ADDRESS <b>5440 Taylor Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5440 Taylor Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ethel Clair Butler</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1880</b>
9. AGE (In years) <b>86</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>29</b> Hours <b>19</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		14. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. FATHER'S NAME <b>Christopher C. Sypolt</b>		16. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>235 18 2675</b>	
19. INFORMANT <b>Mrs. Nellie V. Kline</b>		Address <b>Same as #2 (daughter)</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO <b>Myocardial insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
22a. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1965, to <b>April 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 29, 1967</b> , and that death occurred at <b>12:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Don B. Cameron</b> M.D.		22b. DATE SIGNED <b>April 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>DON B. CAMERON</b>		22d. ADDRESS <b>3503 PERRY ST. MT. RAINIER</b>	
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>		23b. DATE THEREOF <b>5/2/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenway</b>		23d. LOCATION (City or Town) (County) (State) <b>Burkley Springs West Va</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



65220

05558



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05579

5579

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 3000, Upper Marlboro, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sheldon</b> Middle <b>Elwood</b> Last <b>Cadle</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/27/89</b>
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Brooke Cadle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Strong</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Horace S. Cadle</b>		1514 Ritchie Rd., Washington, D.C. 20028	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> DUE TO (b) <b>Diabetic Acidosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>April 5, 1967</b> to <b>April 10, 1967</b> , that (we) last saw the deceased alive on <b>April 10, 1967</b> , and that death occurred at <b>1:15 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>B. Bahrami</b>		22b. DATE SIGNED <b>4/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. Bahrami, M.D.</b>		22d. ADDRESS <b>3001 Nglr Rd. S.E., D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Belair Md.</b>
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 12 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05579

CERTIFICATE OF DEATH

05579

1917

State of Maryland

County of Prince George's

City of Washington

Ward of Columbia Heights

Block of Columbia Heights

Lot of Columbia Heights

House of Columbia Heights

Room of Columbia Heights

Apartment of Columbia Heights

Office of Columbia Heights

Store of Columbia Heights

Warehouse of Columbia Heights

Factory of Columbia Heights

Workshop of Columbia Heights

Garage of Columbia Heights

Stable of Columbia Heights

Pen of Columbia Heights

Shed of Columbia Heights

Enclosure of Columbia Heights

Field of Columbia Heights

Orchard of Columbia Heights

Vineyard of Columbia Heights

Garden of Columbia Heights

Yard of Columbia Heights

Plot of Columbia Heights

Competition Corporation

Brooks & Co.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #3 Film #G388 3/25/67 ps

CERTIFICATE OF DEATH

05580

05580

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. LENGTH OF STAY IN lb <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Magnolia Gardens Nursing Home</b>		d. STREET ADDRESS <b>4104 Hamilton St.</b>	
3. NAME OF DECEASED (Type or print) <b>Zora First L. Middle Carincross / Cairncross</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 23, 1888</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of last year) <b>Housewife</b>		10b. KIND OF BUSINESS OR <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Balt. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benjamin Franklin Frost</b>		14. MOTHER'S MAIDEN NAME <b>Rosa A</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 28 6239</b>	
17. INFORMANT <b>Wm. W. Carincross</b>		<b>4404 Underwood St. University Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis generalized</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , 19 <b>April 7</b> , 1967, that (I) (we) last saw the deceased alive on <b>April 6</b> 1967, and that death occurred at <b>4:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Leon Levitsky</b>		22b. DATE SIGNED <b>7/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leon Levitsky</b>		22d. ADDRESS <b>Mt Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 11, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. W. Carincross</b>	



05550

CHIT CATE W. BURN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05581

05581

CERTIFICATE OF DEATH

~~XXXXXXXXXX~~ CORRECTED COPY

~~XXXXXXXXXX~~ CORRECTED COPY

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. LENGTH OF STAY IN TB 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLSIDE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 1204 54TH AVE			
3. NAME OF DECEASED (Type or print) First: WILLIAM Middle: HOMER Last: CARDINAL				4. DATE OF DEATH Month: APRIL Day: 28 Year: 1967			
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 1921		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (County & State, or foreign country) GREEN BAY, WISC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLAUDE CARDINAL				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES MED RET MAY \$9		16. SOCIAL SECURITY NO.		17. INFORMANT WIFE		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Infarction, posterior left and right ventricular wall and septum. DUE TO (b) Pneumococcal pneumonia, right upper lobe. DUE TO (c) Pneumococcal septicemia. (c) Severe Coronary arteriosclerosis.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 16 Apr, 1967, to 28 Apr, 1967 that (X) (we) lost saw the deceased alive on 28 Apr 67, and that death occurred at 5:50 AM, from causes and on the date stated above.							
22a. SIGNATURE Maxwell W. Steel Jr				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MAXWELL W. STEEL JR Colonel, USAF MC				22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASH, D.C. 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2 MAY 1967		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND, MARYLAND				25a. REC'D BY REGISTRAR DATE MAY 2, 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION



Corrected certificate Film 5393-10/10/67-- MB.



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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05582

# CERTIFICATE OF DEATH

05582

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b> c. LENGTH OF STAY IN lb <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OXON HILL</b> d. STREET ADDRESS <b>7606 BOCK ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA JOSEPHINE CASTER</b>		4. DATE OF DEATH Month Day Year <b>APRIL 26 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Apr 1897</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>SWEDEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN OSTERLUND</b>		14. MOTHER'S MAIDEN NAME <b>MAHTILDA JOHNSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO NA</b>		16. SOCIAL SECURITY NO. <b>038-12-4662</b>	
17. INFORMANT <b>DAUGHTER</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATHEROSCLEROSIS CORONARY ARTERIES</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>8 April, 19 67</b> to <b>24 April 1967</b> , that <del>(X)</del> (we) lost the deceased on <b>24 April 1967</b> , and that death occurred at <b>2:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>X Maxwell W. Steel, Jr.</b>		22b. DATE SIGNED <b>27 April 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MAXWELL W. STEEL, JR. COLONEL, USAF MC</b>		22d. ADDRESS <b>USAF Hospital Andrews Andrews AFB, Wash DC 20331</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PAWTUCKET</b>	23d. LOCATION (City or Town) (County) (State) <b>WARWICK, R.I.</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO. INC. WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



02223

02223

CONTINUED ON PAGE 1

MAY 1 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05583

CERTIFICATE OF DEATH

05583

1. PLACE OF DEATH a. COUNTY <u>PR Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>same</u> as # <u>1 A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u> as # <u>1 B</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5918 Gallatin St</u>		d. STREET ADDRESS <u>same</u> as # <u>1 D</u>	
3. NAME OF DECEASED (Type or print) <u>MAGGIE IRENE CAUDILL</u>		4. DATE OF DEATH <u>APR 28 1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (County & State, or foreign country) <u>ASH Co. N. Carol.</u>
13. FATHER'S NAME <u>Byron Sturgell</u>		14. MOTHER'S MAIDEN NAME <u>Martha Pennington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS GLADYS GREER</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> DUE TO (b) <u>Hypertensive/arteriosclerotic</u> DUE TO (c) <u>Cardio Vascular Disease &amp; Hemiplegia 15yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hr +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>67</u> to <u>APR 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>APR 27</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> M, from causes on the date stated above.			
22a. SIGNATURE <u>M. E. Etienne</u>		22b. DATE SIGNED <u>4-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>4713 Berwyn Rd</u>		22d. ADDRESS <u>College Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashlawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Jefferson n.c.</u>
24. FUNERAL DIRECTOR <u>Francis Hasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
		DATE <u>MAY 2 1967</u>	



05553

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05584

CERTIFICATE OF DEATH

05584

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN Tb <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>12613 Craft Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>(NMN)</b> Last <b>Celich Sr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>22 Dec., 1916</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Anylist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Iso Celich</b>		14. MOTHER'S MAIDEN NAME <b>Eva Hidech</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>389-10-1553</b>	
17. INFORMANT <b>Mrs. Dorothy K. Celich, Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis with Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSION - 15/10</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> , 19 to <b>4-26</b> , 19, that (I) (we) last saw the deceased alive on <b>4-26</b> , 19, and that death occurred at <b>2:25 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Albert Roth</b>		22b. DATE SIGNED <b>2-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Albert Roth, M. D.</b>		22d. ADDRESS <b>5409 Riverdale Rd. Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 29, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Wheaton, Maryland</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co.</b>		25. REC'D BY REGISTRAR <b>MAY 1 1967</b>	
25a. ADDRESS <b>Riverdale, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



05584

STATEMENT OF DEATH

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Deceased's Name

Deceased's Name

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05585

## CERTIFICATE OF DEATH

05585

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN lb <b>Carroll Manor</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Manor</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>-----</b> b. COUNTY <b>-----</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>1504 23rd. St., SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary Veronica Chappellear</b> First Middle Last <b>Female</b> <b>White</b> <b>WIDOWED</b> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>4. DATE OF DEATH</b> <b>April 17 1967</b> Month Day Year <b>8/15/1886</b> <b>80</b> 9. AGE (In years last birthday) yrs.				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret-Examiner-Bureau of Engraving</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Charles Co., Md.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Thomas J. Chappellear</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Ellen Rose Morris</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>		<b>17. INFORMANT</b> <b>Hospital Records</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> 4200 DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>7 days 1 year</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Interstitial Pneumonia</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from Oct. 7, 1958, to April 17, 1967, that (I) (we) last saw the deceased alive on April 17, 1967, and that death occurred at 11:30 PM, from causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>Thomas F Collins</b>			<b>22b. DATE SIGNED</b> <b>p.m.</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Thomas F Collins, M.D.</b>		
<b>22d. ADDRESS</b> <b>322 H St. N.E. Washington, D.C.</b>			<b>22e. REC'D BY REGISTRAR</b> <b>APR 20 1967</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/20/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>			
<b>23d. LOCATION (City or Town)</b> (County) (State) <b>Suitland, Maryland</b>		<b>23e. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>					
<b>24. FUNERAL DIRECTOR</b> <b>Jas. T. Ryan, Inc.</b>			<b>24a. ADDRESS</b> <b>317 Pa. Ave., SE DC</b>				



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05586

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>30 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>20 E. Hillside Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Faith M. Charland</b>				4. DATE OF DEATH Month Day Year <b>April 11 19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1902</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Polkey</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>386-03-5156</b>		17. INFORMANT <b>Mr. Neil F. Charland - Dr., Carrollton,</b>		Address <b>8324 - Verona</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cirrhosis of the Liver</b> (b) <b>30 Days</b> DUE TO (c) <b>30 Days</b>				INTERVAL BETWEEN ONSET AND DEATH <b>30 Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <del>this hospital</del> attended the deceased from <b>March 12, 1967</b> , to <b>April 11, 1967</b> , that (1) <del>was</del> last saw the deceased alive on <b>April 11, 1967</b> , and that death occurred at <b>1:45 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Samuel J. Sugar</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-12-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel J. Sugar, M.D.</b>				22d. ADDRESS <b>4637 Eastern Ave. Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Com.</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash., D.C.</b>	
24. FUNERAL DIRECTOR <b>Home Inc. Nalley's Funeral Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>APR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

05587

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05585

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>4 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmody Hills</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's Hospital</b>				d. STREET ADDRESS <b>7403 C Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alfred Benjamin Clark</b>		First Middle Last		4. DATE OF DEATH <b>April 30 19 67</b>		Month Day Year	
5. SEX <b>male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-22-47</b>	
9. AGE (In years lost birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred B. Clark, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Clarice Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-50-5134</b>		17. INFORMANT <b>Alfred B. Clark, Sr.</b>		Address <b>Same as 2d.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> <b>8234</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Right pneumothorax</b> (c) <b>Trauma - auto accident</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>4 hours</b> <b>4 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car which ran off road and collided with cement</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:45AM 4-30-67</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>aboutment</b>		20e. (City or town) (County) (State) <b>Ritchie Marlboro Rd. s. of Whitfield Rd. P.G.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>4-30-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-3-67</b>		23b. DATE THEREOF <b>Resurrection Cem.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>C Clinton Md</b>		23d. LOCATION (City or Town) (County) (State) <b>Riverdale, Md.</b>	
24. FUNERAL DIRECTOR <b>Rollins Funeral Home</b>		ADDRESS <b>4339 - Hunt Pl</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05588

CERTIFICATE OF DEATH

05588

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEAT PLEASANT</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HYATTSVILLE NURSING HOME</b>			d. STREET ADDRESS <b>6315 FIELD STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ELIZABETH O. CLARK</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>19 67</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 14, 1874</b>		9. AGE (In years lost birthday) yrs. <b>92</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON D. C.</b>	
13. FATHER'S NAME <b>GEORGE WHITE</b>			14. MOTHER'S MAIDEN NAME <b>ISABELLE PIERCE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>IRENE E. OLIVER 6315 FIELD STREET SEAT PLEA.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO (b) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) <b>Arteriosclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>p.m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-10</b> , 1967, to <b>4-26</b> , 1967, that (I) (we) last saw the deceased alive on <b>4-24</b> , 1967, and that death occurred at <b>6:00</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Donald C. Edgren</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-26-67</b>
22c. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGREN</b>			22d. ADDRESS <b>Hyattsville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CONGRESSIONAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON D. C.</b>
24. FUNERAL DIRECTOR <b>ROBERT E. WILHELM</b> ADDRESS <b>4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>			25a. REC'D BY REGISTRAR DATE <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>



05288

UNITED STATES OF AMERICA

05288

MAY 1 1965



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

05589

05589

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>3 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>9736 52nd. Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Helena SMITH Cleveland</b>		4. DATE OF DEATH Month <b>4</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-1898</b>
9. AGE (In years lost birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ADELBERT SMITH</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578 341101</b>	
17. INFORMANT <b>STEWART CLEVELAND</b>		Address <b>5522 KENNEDY ST RIVERDALE, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO <b>Phlebo thrombosis both femoral veins</b> (b) <b>From immobilization from fracture of femur.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>AM</b> p.m. <b>3-30-</b> 19 <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-21-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 23, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>AUGUSTA, MAINE</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS Co. RIVERDALE, MD</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



05533

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Prison (Foot)

Prison (Foot)

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CERTIFICATE OF DEATH

05590

05590

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>12 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>8610 Cunningham Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Vance</b> Middle <b>E.</b> Last <b>Coffey</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-15-94</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>16</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret Iron Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charlie Coffey</b>		14. MOTHER'S MAIDEN NAME <b>Sophonra Phipps</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>409-05-5120</b>	
17. INFORMANT <b>Medical Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: <b>4201 Myocardial infarction</b> IMMEDIATE CAUSE (a) <b>AS HD</b> DUE TO (b) <b>Asternal insufficiency</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/17, 1967</b> , to <b>4/29, 1967</b> , that (I) (we) last saw the deceased alive on <b>4/28, 1967</b> and that death occurred at <b>4:40 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>F. P. Chiaramonte</b>		22b. DATE SIGNED <b>4/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. P. Chiaramonte, M. D.</b>		22d. ADDRESS <b>4307 Branch Ave. Marlow Hgts., Md.</b>	
23a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/2/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>MAY 5 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2c & d Film #G387 4/13/67 pc

05591

CERTIFICATE OF DEATH

05591

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CLINTON MEDICAL CENTER</u>		d. STREET ADDRESS <u>9165 Old Fort Road</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>A.</u> Last <u>Colbert</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 4 1898</u> 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>MR. WILLIAM COLBERT</u>		14. MOTHER'S MAIDEN NAME <u>MRS. ISABELLA HARRISON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. EMMA BOLDEN</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>1531</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Carcinoma splenic flexure of large bowel 6 mm.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Accident</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>67</u> , to <u>4/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/4</u> , 19 <u>67</u> , and that death occurred at <u>7:20</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Steven Christian M.D.</u>		22b. DATE SIGNED <u>4/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEVEN CHRISTIAN M.D.</u>		22d. ADDRESS <u>1534 16th St. NW Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4--8-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Chapel Hill, Maryland</u>	
24. FUNERAL DIRECTOR <u>Phonics Funeral Home Wash. DC.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



052591

CERTIFICATE OF BIRTH

052591

UNITED STATES DEPARTMENT OF HEALTH

MALE NAME

DATE OF BIRTH

PLACE OF BIRTH

NAME OF MOTHER

NAME OF FATHER

NAME OF MARITAL STATUS

NAME OF OCCUPATION

NAME OF RELIGION

NAME OF RACE

NAME OF COLOR

NAME OF SEX

NAME OF SIGNATURE

NAME OF OFFICIAL

NAME OF DATE



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05592

CERTIFICATE OF DEATH

05592

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Glenn Dale)</b>		c. LENGTH OF STAY IN TB <b>25 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Glenn Dale)</b>		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>Glenn Dale Hospital</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James Shields Conant</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 7, 1906</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Amsterdam, N.Y.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James B. Conant</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Fritsch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>560-24-6775</b>	
17. INFORMANT <b>Ellen Conant - wife -</b>		Address <b>Glenn Dale Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <b>Arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/9</b> , 19 <b>67</b> , to <b>4/9</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/9</b> , 19 <b>67</b> , and that death occurred at <b>7:35</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Y.C. Koh</b>		22b. DATE SIGNED <b>April 9, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Yeong-Cheol Koh, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>4/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Amsterdam, New York</b>
24. FUNERAL DIRECTOR <b>Joseph Hawley Sons, Inc. Wash., D.C.</b>		25a. REC'D BY REGISTRAR <b>APR 12 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02222

02222

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TIME: [Illegible]

PLACE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THRU: [Illegible]

INFO: [Illegible]

NOTE: [Illegible]

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CLASSIFICATION: [Illegible]

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DATE: [Illegible]

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APPROVAL: [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05593

CERTIFICATE OF DEATH

05593

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORESTVILLE</b>		c. LENGTH OF STAY IN 1b <b>UPPER MARLBORO</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>REGENT NURSING HOME</b>		d. STREET ADDRESS <b>4720 ROBBIE DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>Emelia R. Cornelison</b>		4. DATE OF DEATH Month <b>Apr</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 12, 1883</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b> Hours <b>19</b> Mins. <b>67</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>ASLAND PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>WILHIMINIA UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HARRY CORNELISON SAME AS # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary thrombosis</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Bronchopneumonia Rt. Lower lobe</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. 1 certify that (I) (this hospital) attended the deceased from <b>7-3</b> , 1966, to <b>4-27</b> , 1967, that (I) (we) last saw the deceased alive on <b>4-27</b> , 1967, and that death occurred at <b>3:59</b> P.M. from causes on and on the date stated above.			
22a. SIGNATURE <b>W.D. Sheer</b>		22b. DATE SIGNED <b>4-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER B. SHEER</b>		22d. ADDRESS <b>6400 MARLBORO PIKE SE. WASH. D.C. 20028</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/1/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MUNCY CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MUNCY, PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR <b>ROBERT E. WILHELM FUNERAL HOME</b> <b>4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05594

Item #2a,b,c & d Film #3389 5/23/67 pc

CERTIFICATE OF DEATH

05594

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier Wash, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Manor</b>		d. STREET ADDRESS <b>2109 Ft Davis, S.E.</b> <b>4922 LaSalle Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>E.</b> Last <b>COVELL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years and birth day) <b>84</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Emerson</b>		14. MOTHER'S MAIDEN NAME <b>Violet Kraft</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Rev. Frederick Bloom-Rockville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>4 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1967</b> , to <b>April 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 4, 1967</b> , and that death occurred at <b>4:40 P.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Timothy F O'Donovan M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/17/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Timothy F.O'Donovan</b>		22d. ADDRESS <b>4400 Stanb Rd, Rockville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Comfort</b>	23d. LOCATION (City or Town) (County) (State) <b>Alexandria, Va.</b>
24. FUNERAL DIRECTOR <b>Lyson Wheeler Funeral Home</b>		ADDRESS <b>1331 Rockville Pike, Rockville, Md.</b>	25a. REC'D BY REGISTRAR <b>APR 19 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Nursing Home		d. STREET ADDRESS 4013 8th Street N.E.	
3. NAME OF DECEASED (Type or print) Catherine R Cox		4. DATE OF DEATH April 8 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
13. FATHER'S NAME Thomas Elliott		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT Levi Cox Same as # 2	
16. SOCIAL SECURITY NO. 579-52-4439		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1966 to 8 Apr 1967, that (I) (we) last saw the deceased alive on 7 Apr 1967, and that death occurred at 5:42 M, from the causes and on the date stated above.			
22a. SIGNATURE J. H. Thibadeau		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. H. Thibadeau		22d. ADDRESS 3112-4th Ave. S.E. DC 20020	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Prince George Co Md	
24. FUNERAL DIRECTOR Robert A. Mattingly		25a. REC'D BY REGISTRAR APR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05596

05596

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>Rt. 2, Box 119</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank Thomas Crampton</b>				4. DATE OF DEATH Month Day Year <b>4 13 19 67</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 Jan. 1908</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GARDINER</b>		11. BIRTHPLACE (State or foreign country) <b>WASH. D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN W. CRAMPTON</b>				14. MOTHER'S MAIDEN NAME <b>CORA PENNIFIELD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>578-05-3424</b>		17. INFORMANT <b>MRS. CRAWFORD WILLIAMS, WALDORF, MD.</b> Address <b>RT 2 BOX 119</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 7 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes - over 15 years.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				22. DATE SIGNED <b>4-14-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-17-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEM. GARDENS</b>		23d. LOCATION (City or Town) (County) (State) <b>WALDORF, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>HUNTT FUNERAL HOME, WALDORF, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05597

CERTIFICATE OF DEATH

05597

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN lb Seat Pleasant 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home 8100-Marlboro Pike SE		d. STREET ADDRESS 512--Rollins Ave., SE	
3. NAME OF DECEASED (Type or print) Barbara L. Cristofani		4. DATE OF DEATH Month April Day 5th Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28-1873
9. AGE (In years last birthday) yrs. 93		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Hanover, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Lonce		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Katharine A. Keller		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARTERIOSCLEROSIS DUE TO 4201 (b) CORONARY INSUFFICIENCY DUE TO (c) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 5-10 yrs YES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11, 1960, to 4/5, 1967, that (I) (we) just saw the deceased alive on 4/5, 1967, and that death occurred at 3:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Cullen		22b. DATE SIGNED 4/5/67	
22c. PHYSICIAN'S NAME (Type) Thomas F. Cullen MD		22d. ADDRESS 5103 Marlboro Road, SE 1094C	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 8-1967	23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery	23d. LOCATION (City or Town) (County) (State) Hanover, Pennsylvania
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR DATE APR 7 1967	
ADDRESS 1661-Good Hope Rd SE Wash DC		25b. REGISTRAR'S SIGNATURE Charles J. Juge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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OFFICE OF DEAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

05598

05598

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>Approx. 2 wks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>3716 - 37th St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edna W. Davison</b>		4. DATE OF DEATH Month Day Year <b>April 12 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/19/1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>16 1</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Health, Educ. &amp; Welfare</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Davis N. Wiley</b>		14. MOTHER'S MAIDEN NAME <b>Hanna L. Eshbaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-32-7670</b>	
17. INFORMANT <b>Mr. Robert M. Davison - (Son)</b>		Address <b>10814 - Jowett St., Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cerebrovascular disease</b> DUE TO (c) <b>3 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/25, 1967</b> , to <b>4/12, 1967</b> , that (I) (we) last saw the deceased alive on <b>4/12/67</b> 19, and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>R.A. Mendelsohn</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert A. Mendelsohn, M. D.</b>		22d. ADDRESS <b>1012 Spring St., Silver Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meade Chapel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brookville, Penna.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>	
ADDRESS <b>Mt. Rainier, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05599

CERTIFICATE OF DEATH

05599

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN lb <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland mem Hosp</u>				d. STREET ADDRESS <u>1007 10th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Mary</u> Last <u>Davidson</u>				4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-88</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>California</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles D. Webster</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Erikson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>daughter Jean Krog</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GEN. ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>							INTERVAL BETWEEN ONSET AND DEATH <u>17 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> , 19 <u>67</u> , to <u>4-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-13</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>C. J. Houmann</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>				22d. ADDRESS <u>RIVERDALE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>April 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Lynbrook Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Calver Manor - P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Butt &amp; Bonafant Laurel, Md.</u>				25a. READ BY REGISTRAR DATE <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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OFFICIAL OF BOARD

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*[Faint, illegible handwritten text, possibly a ledger or record book entry]*



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05600

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05600

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>	
c. LENGTH OF STAY IN lb <b>DOA</b>		d. STREET ADDRESS <b>9820 ALLENTOWN ROAD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ANDREWS AIR FORCE BASE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>E</b> Last <b>DAY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 30, 1910</b>
9. AGE (In years lost birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSTALLER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE COMPANY</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ERNEST E. DAY</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE G. STAMP</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ERNEST E. DAY 3009 8th St. S.E. WASH. D.C.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Sclerosis</b> (b) <b>Hypertensive C.V. Disease</b> DUE TO <b>3 years</b> (c) <b>Interval between onset and death</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dgh Wall</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>DAYTON O Wath</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>4-6-67</b>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/8/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGES, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>ROBERT E. WILHELM</b> ADDRESS <b>4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Michaela Judge</b>	



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05601

CERTIFICATE OF DEATH

05601

1. PLACE OF DEATH a. COUNTY <i>Prince Georges Co., MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Pa.</i> b. COUNTY <i>CLAY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MARKLEYSBURG - Pa 15</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Southern md. Medical Center</i>		d. STREET ADDRESS <i>RT # 1 - Box 20A</i>	
3. NAME OF DECEASED (Type or print) <i>Harold J Denver</i>		4. DATE OF DEATH Month <i>April</i> Day <i>16</i> Year <i>1967</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/31/1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CARPENTER</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>NEW JERSEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JACK H. DENVER</i>		14. MOTHER'S MAIDEN NAME <i>GERTRUDE MILLER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>MARY P. DENVER, wife at #2</i>		Address <i>same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO (b) <i>Myocardial Infarction, massive</i> DUE TO (c) <i>Cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-7</i> , 19 <i>67</i> , to <i>4-16</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-16</i> , 19 <i>67</i> , and that death occurred at <i>2:04</i> AM, from causes and on the date stated above.			
22a. SIGNATURE <i>Alfred R. Lapin, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4/16/67</i>
22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN, M.D.</i>		22d. ADDRESS <i>CLINTON, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>April 18-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Burial</i>	23d. LOCATION (City or Town) (County) (State) <i>Bladensburg Md</i>
24. FUNERAL DIRECTOR <i>Simmons Bros</i>		ADDRESS <i>1661-44th St NE</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>
25b. REGISTRAR'S SIGNATURE		DATE <i>APR 19 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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05602

## CERTIFICATE OF DEATH

05602

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>			c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>323 17th Street, S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bennie Dobson</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-1896</b>		9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Isaac Dobson</b>				14. MOTHER'S MAIDEN NAME <b>Rena Mules</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>609-14-4505</b>		17. INFORMANT <b>Decedant</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable pulmonary embolism</b> 4200 DUE TO (b) <b>arteriosclerotic heart disease with congestive heart failure, decompensated</b> DUE TO (c) <b>generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  <b>unknown</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary bullous emphysema and fibrosis; multiple decubiti.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>4/5</b> <b>9:45 P.M.</b> <b>4/12</b> , 1967, that (we) last saw the deceased alive on <b>4/12</b> 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4-17-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGE'S COUNTY, MD.</b>	
24. FUNERAL DIRECTOR <i>Princes Funeral Home</i>				ADDRESS <i>305 North 7th St</i>		25a. REC'D BY REGISTRAR <b>APR 18 1967</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal of any event, within 72 hours after death.



05603

05603

D.O.

Prince George

Washington

7 Ave

Glenn Dale (true)

322 17th Street, S.W.

Glenn Dale Hospital

April

Robert

Female

70

10-22-1900

Female

Male

South Carolina

Married

Kenneth

Isaac Deaton

10-1-1900

Probable pulmonary embolism

arteriosclerotic heart disease with congestive

heart failure, decompensated

generalized arteriosclerosis

Autopsy: bilateral emphysema and fibrosis; multiple atherosclerosis.

9:30 P.M. 1912

Glenn Dale Hospital  
Glenn Dale, Maryland

Glenn Dale, Md.



05603

CERTIFICATE OF DEATH

05603

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>PR. GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughenville</u>	
c. LENGTH OF STAY IN 1b		d. STREET/ADDRESS <u>Rt. 1-Box 152</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH DORSEY</u>		4. DATE OF DEATH <u>April 8-1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>71</u> yrs.
9. DATE OF BIRTH <u>July 30, 1895</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Chas. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown William Leonard</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-24-8904</u>	
17. INFORMANT <u>Mary C. Dorsey</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Collapse</u> DUE TO <u>Diabetes Mellitus advanced</u> DUE TO <u>Pancreatic Hepatic Disease</u> lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-16, 1967</u> to <u>4-8, 1967</u> that (II) (we) lost saw the deceased alive on <u>4-8, 1967</u> and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr. 14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Church Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Bryantown Chas. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Martell Adams Aquasco, Md.</u>		25a. REC'D BY REGISTRAR <u>gcharles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>APR 17 1967</u>	



07263

15326



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05604

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05604

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		d. STREET ADDRESS <b>7016 Taylor St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Allen Edens</b>		4. DATE OF DEATH Month <b>4</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 July 1897</b>
9. AGE (In years last birthday) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Traffic Manager</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel Edens</b>		14. MOTHER'S MAIDEN NAME <b>Nina Kinningham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) <b>yes WW 1</b>		16. SOCIAL SECURITY NO. <b>578 05 7020</b>	
17. INFORMANT <b>Beatrice G Edens</b>		Address <b>Landover Hills, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 3 yrs.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>4-10-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 12, 1967</b>	
23c. NAME OF CEMETERY OR REMOVAL <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



05504

05504

1-10-07

1997



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05605

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05605

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>4 hrs. 5 min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. STREET ADDRESS <b>3107 Windom Road</b>	
3. NAME OF DECEASED (Type or print) <b>Amelia B. Farley</b>		4. DATE OF DEATH Month <b>4</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 April 1912</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beautyician</b>	
11. BIRTHPLACE (State or foreign country) <b>Verona, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James M. Barr</b>		14. MOTHER'S MAIDEN NAME <b>Anna H. McPherson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Dominick L. Alberti</b>		Address <b>1304 Palmdale Dr. St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro intestinal hemorrhage</b> DUE TO (b) <b>( cause undetermined )</b> DUE TO (c) <b>578X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>4-11-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4-13-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Riverdale, Md.</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters</b>		25. ADDRESS <b>254 Carroll St.</b>	
26. DATE <b>APR 13 1967</b>		27. SIGNATURE <b>John Kehoe</b>	



05002

05002

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05606

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>3904 Croydon Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Lawrence Phillip Fern</b>		4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-2-1913</b>
9. AGE (In years lost birthday) yrs. <b>53</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DIRECTOR OF ADMINISTRATION Bldg MEDICINE, U.S.</b>	
11. BIRTHPLACE (State or foreign country) <b>KANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES FERN</b>		14. MOTHER'S MAIDEN NAME <b>MARY Mc CORMICK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>510-03-8952</b>	
17. INFORMANT <b>MAXINE J. FERN</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4200</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 6 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kenoe, M.D.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>4-24-67</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 26, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO. RIVERDALE, MD</b>		25a. REC'D BY REGISTRAR DATE <b>APR 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



2092



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

<div>Items 18&amp;21 Film 389</div> <div>6-19-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>05607</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05607</div>											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, give institution; if not, give residence) a. STATE <b>District of Columbia</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 117.3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5810 Cleveland Street</b>						d. STREET ADDRESS <b>543 23rd. Place, N.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Durham Fields</b>			First Middle Last			4. DATE OF DEATH Month Day Year <b>4 16 19 67</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-10-1908</b>		9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Ooys Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Samuel G. Durham</b>						14. MOTHER'S MAIÖEN NAME <b>Nancy Wyche</b>					
15. WAS DECEASED EVER IN U.S. ARMEO FORCES? (Yes, no, or (unknown)) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. William Boggs-Sister-543 23rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema, massive</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>and bronchial aspiration, mucous</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURREO. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (Stote)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						22. DATE SIGNED <b>4-17-67</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOE <b>4/20/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Ceme. Maryland</b>			23d. LOCATION (City or Town) (County) (Stote)		
24. FUNERAL DIRECTOR <b>Stewart</b>						25a. REC'D BY REGISTRAR <b>APR 20 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



1933

02507

Division of Biological Sciences

Division of Biological Sciences

Washington

Washington

U.S. National Museum

U.S. National Museum

Smithsonian Institution

Smithsonian Institution

Department of the Interior

Department of the Interior

Office of the Director

Office of the Director

Division of Biological Sciences

Division of Biological Sciences

U.S. National Museum, Washington, D.C.

Division of Biological Sciences

U.S. National Museum, Washington, D.C.

1933

John H. Brown, Jr., Director

U.S. National Museum, Washington, D.C.

U.S. National Museum, Washington, D.C.



05608

CERTIFICATE OF DEATH

05608

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo. Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN lb 63 yrs. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mr. Rainier 161	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4206 29th Street		d. STREET ADDRESS 4206 29th Street	
3. NAME OF DECEASED (Type or print) Edward Jerome Flynn		4. DATE OF DEATH April 25 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-02
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Conductor	
10b. KIND OF BUSINESS OR INDUSTRY Penna. Railroad		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Flynn	
14. MOTHER'S MAIDEN NAME Margaret Mannix		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes-Navy 1918	
16. SOCIAL SECURITY NO. 717-07-8480		17. INFORMANT Ernestine Ann Flynn (daughter-in-law)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO acute coronary occlusion (b) arterio sclerosis 2 yrs (c) DUE TO		INTERVAL BETWEEN DEATH AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 1954, to APR 25, 1967, that (I) (we) last saw the deceased alive on APR 11, 1967, and that death occurred at 7:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE L.W. Malin		22b. DATE SIGNED 4-25-67	
22c. PHYSICIAN'S NAME (Type) L.W. MALIN M.D.		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/28/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Com.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR MAY 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MAY 1 1981



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05609

## CERTIFICATE OF DEATH

05609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>16.1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> d. STREET ADDRESS <b>VOQ 1350-6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BENJAMIN DELAHAUF FOULOIS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 DEC 1879</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. AIR FORCE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, CONN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY FOULOIS</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1899-1935</b>		16. SOCIAL SECURITY NO. <b>579-60-2054</b>	
17. INFORMANT <b>MARY K REEVES-GRAND NIECE</b>		Address <b>2515 R ST. S.E. WASHINGTON D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> <b>CARDIORESPIRATORY ARREST</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MULTIPLE CEREBRAL INFARCTIONS</b> DUE TO (c) <b>CEREBROVASCULAR DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> <b>6 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PNEUMONIA</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>19 SEP 1966</b> , to <b>25 APR 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>25 APR 1967</b> , and that death occurred at <b>4:05 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <input checked="" type="checkbox"/> <b>Charles D Phelps</b>		22b. DATE SIGNED <b>25 APR 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES D PHELPS CAPT USAF MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>4-27-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, Conn.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



05000

STATE OF TEXAS

05000

IN SENATE,  
January 2, 1901.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1900.

STATE OF TEXAS	COMMISSIONER OF THE LAND OFFICE
REPORT	FOR THE YEAR 1900
BY	JOHN W. HARRIS
PRINTED BY	THE TEXAS PRINTING CO., DALLAS
1901	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05610

05610

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGE</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN b. <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>FAIRFAX</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ALEXANDRIA</b> d. STREET ADDRESS <b>303 Princeton Blvd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ROBERT F FROST</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>APRIL 9 1967</b>				
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>CAU</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>21 JUN 1911</b>	<b>9. AGE</b> (In years last birthday) <b>55 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>OFFICER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. AIR FORCE</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>FORT DODGE, IOWA</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>FREDERICK R FROST</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY L. WILL</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>YES RET -1960</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>WIFE, SAME AS # 2</b>				<b>17. INFORMANT</b> Address <b>WIFE, SAME AS # 2</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> 1992 DUE TO (b) <b>Metastatic CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Apr. 8, 1967</b> <b>to</b> <b>Apr. 9, 1967</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Apr. 9, 1967</b> , <b>and that death occurred at</b> <b>11:30 AM</b> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Robert L. Mitchell</b> M.D.				<b>22b. DATE SIGNED</b> <b>10 Apr 1967</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>ROBERT L. MITCHELL, CAPT USAF MC</b>				<b>22d. ADDRESS</b> <b>USAF Hospital Andrews</b> <b>Andrews AFB, Wash DC 20331</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>13 April 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>			
<b>23d. LOCATION (City, town or county) (State)</b> <b>Arlington, Virginia</b>		<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Alexandra, Virginia</b> <b>Everly-Wheatley Funeral Home</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>APR 13 1967</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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ENTRANCE

VIRGINIA

PRINCE GEORGE

ALEXANDRIA

ANDREWS AIR FORCE BASE - 1 DAY

LEAF HOSPITAL ANDREWS

PROST

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ROBERT

21 JUN 1951

CAN

MALE

U.S.A.

FORT BODGE, IOWA

U.S. AIR FORCE

OFFICER

MARY L. WILL

PROST

FREDERICK B.

WINE, SAME AS 1

RET - 1950

YES

10 APR 1951

USAF Hospital Andrews  
Andrews AFB, Wash DC 20331

ROBERT L. MITCHELL, CAPT USAF MC

Washington, VA

Washington, VA

APR 13 1951

Every-day - medical care



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
05611						MEDICAL EXAMINER'S CERTIFICATE OF DEATH						05611	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton 16-1							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital						d. STREET ADDRESS 9425 Michael Drive						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marion Frederick Frye						4. DATE OF DEATH Month Day Year April 29 19 67							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1895		9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Martin Frye						14. MOTHER'S MAIDEN NAME Florence Magnolia Matthews							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 577-56-9403		17. INFORMANT Address Allen S. Frye-1326 Canyon Rd. Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (c) 14200 16 years												INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (State, city, town, county) Riverdale, Md.				22. DATE SIGNED 4-29-67					
23a. BURIAL, CREMATION REMOVAL (Specify) burial				23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.				23d. LOCATION (City or town) (County) (State) Suitland, Md/			
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.						25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05613 Item #7 Film #G380 5/2/67 DC  
CERTIFICATE OF DEATH  
05613

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRENTWOOD c. LENGTH OF STAY IN 1b 16.1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3900 39th STREET				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRENTWOOD d. STREET ADDRESS 3900 39th STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA GERTRUDE GIBBONS		4. DATE OF DEATH Month Day Year APRIL 18 1967					
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1886	9. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY U.S.V.B.		11. BIRTHPLACE (County & State, or foreign country) PENNA.			
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JOHN GIBBONS			14. MOTHER'S MAIDEN NAME TERESA HAWKS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARGARET H. ROM Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Cancer 1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cancer of Sigmoid Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 4 yrs.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Feb. 3, 1966, to Apr. 18, 1967, that (I) (we) last saw the deceased alive on Apr. 18, 1967, and that death occurred at 10:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles C. Hageage				22b. DATE SIGNED Apr. 19, 1967			
22c. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D.				22d. ADDRESS 3308 Perry St., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-21-1967		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN			
23d. LOCATION (City, town or county) WHEATON, MARYLAND		(State)					
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD.				25a. REC'D BY REGISTRAR APR 24 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			



05613

1961



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05614

05614

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>4229 30th. Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Anthony Gillis</b>				4. DATE OF DEATH Month Day Year <b>4 3 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 Nov. 24-Oct. 1918</b>	9. AGE (In years lost birthday) yrs. <b>48</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Milestone Liq.</b>		11. BIRTHPLACE (State or foreign country) <b>St. Joseph, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. EATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>494-30-7526</b>		17. INFORMANT Address <b>Mrs. Virginia Gillis (above address) (wife)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 3 mo.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>4-5-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Com.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>		
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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John Jones, M.D., University of  
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John Jones, M.D., University of  
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05615

## CERTIFICATE OF DEATH

05615

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4208 Farragut Street</b>		d. STREET ADDRESS <b>4208 Farragut Street</b>	
3. NAME OF DECEASED (Type or print) <b>CATHARINE W. GLOVER</b>		4. DATE OF DEATH April 26, 1967	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1882</b>
9. AGE (In years birthday) yrs. <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Judson Wakeman</b>		14. MOTHER'S MAIDEN NAME <b>Catharine Conklin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>525 54 4048</b>	
17. INFORMANT <b>Mrs. Catharine Marsden Same as #2 (daughter)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Coronary artery arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery arteriosclerosis</b> (c) <b>10 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-18</b> , 19 <b>64</b> , to <b>4-26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-25</b> , 19 <b>67</b> , and that death occurred at <b>7 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>R.C. Kirchner</b>		22b. DATE SIGNED <b>4-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.C. KIRCHNER</b>		22d. ADDRESS <b>6480 N.H. Ave - TAKOMA PARK Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pohick Church</b>	23d. LOCATION (City or Town) (County) (State) <b>Lorton Va.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05012

STATE OF TEXAS

05012

1931 A 2 84



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05616

05616

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights 1611	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 605 59th Avenue		d. STREET ADDRESS 605 59th Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last William A Godbout		4. DATE OF DEATH Month Day Year April 7 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Godbout		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Helen L. Fillmann 603 71st Ave. Seat Pleasant		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Adenocarcinoma of left lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov, 1942, to Apr. 7, 1967, that (I) (we) last saw the deceased alive on April 4, 1967, and that death occurred at 9:30 AM, from causes and on the date stated above.			
22a. SIGNATURE W H Clements		22b. DATE SIGNED April 7, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-1967	
23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland		25a. REC'D BY REGISTRAR APR 11 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			



05216

05216

APR 11 1967

APR 11 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05617

05617

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P. G.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine			
c. LENGTH OF STAY IN 1b unknown				d. STREET ADDRESS 276A Route 2 Brandywine			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Residence, Box 276 A, Rt 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Gladys		Middle Melvina		Last Graff	
4. DATE OF DEATH		Month 4		Day 24		Year 1967	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1892	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Deltaville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron Jackson				14. MOTHER'S MAIDEN NAME Melvina (unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) Unknown		17. INFORMANT 1301 Fernell Rd. Mrs. Ella L. Burns Severna Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X Cerebro-vascular accident DUE TO (b) Acute Grapical illness Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) VOMITING, PERNICIOUS, 3 DAYS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/17, 1964 to DEATH, that (I) (we) last saw the deceased alive on 4/22/67, 19, and that death occurred at 4:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Robert W. Merkle				22b. DATE SIGNED 4/24/67		22c. PHYSICIAN'S NAME (Type) Robert W. Merkle	
22d. ADDRESS Waldorff, Maryland				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/28/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park		23d. LOCATION (city, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR R.V. SINGLETON,				25a. REC'D BY REGISTRAR DATE APR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



05617

05617

Mr. J. Edgar Hoover  
Director, Federal Bureau of Investigation  
Washington, D. C.  
Dear Sir:

Very truly yours,  
W. H. Rouse



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

05618

CERTIFICATE OF DEATH

05618

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE, MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW GARDENS</u>		d. STREET ADDRESS <u>CLINTON, MD.</u>	
3. NAME OF DECEASED (Type or print) <u>GRAHAM FRANCIS Arlee Graham</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>NE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-89</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>COOPER, MARY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-388544B</u>	
17. INFORMANT <u>GROSS, LOUISE</u>		Address <u>BRANDYWINE, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-4</u> , 19 <u>67</u> , to <u>4-21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-21</u> , 19 <u>67</u> , and that death occurred at <u>1:34</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin, MD.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD.</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Ch. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Halltown, Ches. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Marcell Adams Agnasci, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME	



05618

81320



05619

## CERTIFICATE OF DEATH

05619

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>			c. LENGTH OF STAY IN 1b <u>161</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkshire</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care</u>						d. STREET ADDRESS <u>7316 Hamford St</u>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>N</u> Last <u>Geant</u>				4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8-20-91</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WILLIAM R. DUBOIS</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Van Dusen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>JAMES VERNON 2900 ST CLAIR DR SE</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Concussion of ureters related</u> (c) <u>3 mon</u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia, hypochromic perne</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2-27</u> , 19 <u>67</u> , to <u>4-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-13</u> , 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lapin, MD.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD</u>				22d. ADDRESS <u>CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES MD.</u>	
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm</u>				ADDRESS <u>4308 SUITLAND Rd SUITLAND MD.</u>		25. RECD BY REGISTRAR <u>APR 17 1967</u>	
				26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05019

CERTIFICATE OF DEATH

05019

Name of Deceased		Date of Birth		Sex	
Place of Birth		Date of Death		Time of Death	
Cause of Death		Place of Death		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Entry		Date of Filing		Date of Issuance	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE NATIONAL BUREAU OF VITAL STATISTICS AND RECORDS, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, UNITED STATES OF AMERICA.



## CERTIFICATE OF DEATH

05620

05620

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Ieland Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> d. STREET ADDRESS <u>4506 Banner Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> First Middle Last <u>II</u> <u>Green</u>			4. DATE OF DEATH Month Day Year <u>4</u> <u>8</u> <u>19 67</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-95</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 Year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>JERMAH GREEN</u>			14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-0280</u>		17. INFORMANT <u>Claudette Randall</u> Address <u>same address</u> <u>Hospital admitting record</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>41200</u> DUE TO <u>Coronary Heart Failure</u> (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>General arteriosclerosis and atherosclerosis</u> (c) <u>and atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Stomach</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>Apr 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr 7</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>L W Malin</u>			22b. DATE SIGNED <u>Apr 8, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>L W MALIN M.D.</u>			22d. ADDRESS <u>Riverdale, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D. C.</u>				
24. FUNERAL DIRECTOR <u>John T. Rhine</u>			25a. REC'D BY REGISTRAR DATE <u>APR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02250

02250

John T. Hines - Secretary

April 1st 1994



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05621

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05621

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>7414 Wilhelm Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elbert William Grover</b>				4. DATE OF DEATH Month Day Year <b>4 17 67</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-6-1901</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MOTION PICTURE, INDY</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN GROVER</b>				14. MOTHER'S MAIDEN NAME <b>LILIAN SAUER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577 07 6158</b>		17. INFORMANT <b>MRS MARION T. GROVER</b> Address		<b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>over 1 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes - over 18 yrs.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b> Riverdale, Md.				22. DATE SIGNED <b>4-18-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>APRIL 20, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS, CO. RIVERDALE, MARYLAND.</b>				25a. REC'D BY REGISTRAR <b>APR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05622					CERTIFICATE OF DEATH			05622	
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, District of Columbia</b> d. STREET ADDRESS <b>1602 - 61st St., S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles L. Grubbs</b>					4. DATE OF DEATH Month Day Year <b>April 12, 1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/10/17</b>		9. AGE (In years last birthday) <b>49</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supply Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Air Force</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Clark Co. Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther L. Grubbs</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Tavenor</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>W.W. 2 1942 - 1945</b>			16. SOCIAL SECURITY NO. <b>579-09-6989</b>		17. INFORMANT <b>Irene D. Grubbs Same As #2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brochopneumonia - bilateral</b> <b>583X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary edema</b> DUE TO (c) <b>Hepatic failure (clinical)</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 26, 1967</b> , to <b>April 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 12, 1967</b> , and that death occurred at <b>10:30 AM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Mark Pillor, M.D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIR. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Mark Pillor, M.D.</b>					22d. ADDRESS <b>7200 Marlboro Pike, District Hgts, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/17/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland Prince Geo. Md.</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc. 517 11th St. S.E., Wash. D.C.</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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the cross  
Clark Co. 1942  
1. 1942

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05623

FOR STATE  
HEALTH DEPT

05623

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. LENGTH OF STAY IN tb <b>64 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Magnolia Gardens Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William L. Gscheidle</b>		4. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 Dec., 1876</b>
9. AGE (In years lost birthday) yrs. <b>90</b>		10. IF UNDER 1 Year Months Days Hours Min. <b>27 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - U.S. Govt. Dep. Agriculture</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Gscheidle</b>		14. MOTHER'S MAIDEN NAME <b>Emma Schelle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-52-6049</b>	
17. INFORMANT <b>Mrs. Rose E. Gscheidle</b>		Address <b>(above address)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Over 10 y</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intertrochanteric fracture of left femur</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in living room of home</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>pm</b> <b>x 1</b> <b>16</b> <b>19</b> <b>67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>4-28-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.,</b>		Address (Street, city, town, or county) <b>Colmar Manor, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/1/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25. REC'D BY REGISTRAR <b>MAY 2 1967</b>	
ADDRESS <b>Mt. Rainier, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



02023

02023

MAY 2 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2c & d Film #G388 5/11/67 pc

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>118 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>3211 Bunker Hill Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Hageage</b> Last <b>Hageage</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 July 1887</b>
9. AGE (In years last birthday) <b>79</b> Yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>5</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Lebanon</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nasaralla Nofil</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Edmond Hageage - Son</b>		Address <b>1627 - Drexel St., Takoma Pk. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>April 17, 1967</b> , to <b>April 17, 1967</b> , that (I) (we) saw the deceased alive on <b>April 17, 1967</b> , and that death occurred <b>at 4:00 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Leon R. Levitsky, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Leon R. Levitsky, M.D.</b>		22d. ADDRESS <b>3408 Rhode Island Ave. Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/20/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Com.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. RECEIVED BY REGISTRAR <b>APR 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



05824

05824

05824

Prince George's  
General Hospital  
215 days  
Prince George's  
General Hospital  
215 days  
20 July 1987

*[Faint, illegible handwritten text and markings, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #17 Film #G387 4/17/67 pc									
05625									
05625									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS Box 416			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henrietta Kerr Hall					4. DATE OF DEATH Month Day Year April 6, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1881		9. AGE (In years birth day) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Prince George, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard Henry Hall					14. MOTHER'S MAIDEN NAME Henrietta Spalding				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 220 44 8349T		17. INFORMANT Evelyn Miss Eva Hall Same as #2 (sister) Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ <th colspan="2">INTERVAL BETWEEN ONSET AND DEATH</th>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced arteriosclerosis</u> <th colspan="2">19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></th>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <th colspan="7">20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</th>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 <th colspan="2">20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><th colspan="2">20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<th colspan="2">20f. (City or town) (County) (State)</th></th></th>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <th colspan="2">20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<th colspan="2">20f. (City or town) (County) (State)</th></th>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <th colspan="2">20f. (City or town) (County) (State)</th>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1967</u> to <u>April 6, 1967</u> that (I) (we) last saw the deceased alive on <u>March 25, 1967</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Don B Cameron</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 6, 1967</u>		
22c. PHYSICIAN'S NAME (Type) Don B Cameron					22d. ADDRESS Mt. Rainier, Md.				
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial			23b. DATE THEREOF 4/8/67		23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Church		23d. LOCATION (City or town) (County) (State) Collington P.G. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE APR 10 1967		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>		



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Prince George General Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

(M)

05626

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05626

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> c. LENGTH OF STAY IN 1b <b>16-1</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>*****</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro,</b> d. STREET ADDRESS <b>Box 3139 Chew, Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MADISON</b> Middle <b>William</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>4</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-1895</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>William Hall</b>		15. MOTHER'S MAIDEN NAME <b>Mary Forbes</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		17. SOCIAL SECURITY NO. <b>215-12-1447</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric hemorrhage</b> <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of stomach</b> (c) <b>151X</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/28, 1965</b> to <b>4/6, 1967</b> , that (I) (we) last saw the deceased alive on <b>4/6, 1967</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas L. Fieldson</b>		22b. DATE SIGNED <b>4/6, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS L. Fieldson M.D.</b>		22d. ADDRESS <b>BYANDY WINE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>McGuire Funeral Service</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>1820 9th St., N.W. Washington, D.C.</b>	



burial 4/10/67  
 service [funeral] service Washington, D.C.  
 1820 9th St., N.W.  
 Mt. Olivet Cemetery Washington, D.C.

no  
 William Hall  
 retired  
 Maryland  
 Mary Forbes  
 215-12-1447 William Washington, Maryland  
 608 Willow Ave, Upper Marlboro  
 M  
 C  
 X  
 2.14.1892  
 75  
 Maryland  
 USA  
 Box 1139 Glen, Road  
 Upper Marlboro,  
 Maryland  
 Prince George  
 Upper Marlboro  
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05627

## CERTIFICATE OF DEATH

05627

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>P. Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OXEN HILL</b>		161	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PINEVIEW GARDENS HEALTH CARE CENTER</b>				d. STREET ADDRESS <b>5916 Muir Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OCTAVIA</b> Middle <b>S.</b> Last <b>HALL</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1967</b>			
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-70</b>	9. AGE (In years last birthday) <b>96</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia Bland Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>YES</b>	
13. FATHER'S NAME <b>CHARLES SNEAD</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>228-70-6516 JI</b>		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic &amp; Hypertensive</b> DUE TO <b>Cardiovascular Disease</b> 44							INTERVAL BETWEEN ONSET AND DEATH <b>4-5 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 30, 1967</b> , to <b>April 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 29, 1967</b> , and that death occurred at <b>9:25 p.m.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Walcott W. Gibson</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walcott W. GIBSON, M.D.</b>				22d. ADDRESS <b>4300 50, Baynaber Road, Marlow Heights, Md. 20031</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bland Virginia</b>	
24. FUNERAL DIRECTOR <b>J. Wm. Lee &amp; Sons</b>				ADDRESS <b>4th &amp; Mass. Wash, D. C.</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

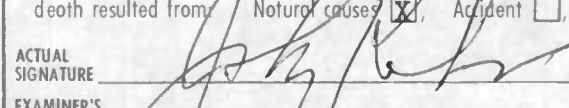

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05628

05628

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>1114 52nd Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Edward Hamilton</b>			4. DATE OF DEATH Month Day Year <b>4 20 19 67</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-16-35</b>		9. AGE (In years last birthday) yrs. <b>31</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Station</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ma</b>	
13. FATHER'S NAME <b>Robert E. Hamilton</b>			14. MOTHER'S MAIDEN NAME <b>Alice Akers</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-30.6940</b>		17. INFORMANT <b>Mabel E Hamilton</b> Address <b>same 2.D</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 358.2 DUE TO (b) <b>Status epilepticus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Cerebral dural adhesion (right temporal lobe)</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		22. DATE SIGNED <b>4-22-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4.25.67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria, National</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home 300.4th st N E</b>		23d. LOCATION (City or Town) (County) (State) <b>Alexandria, Virginia</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	
				25b. REGISTRAR'S SIGNATURE 	



05028

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2d & 16 Film #G388 5/12/67 pc

05629

## CERTIFICATE OF DEATH

05629

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Hour.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Francis</b> Last <b>Hammett</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1898</b>
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Allen Hammett</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Hartley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give year or dates of service) <b>Army WWI</b>		16. SOCIAL SECURITY NO. <b>215 26 0443</b>	
17. INFORMANT <b>Mrs. Bertha V. Hammett</b>		Address <b>Same as #2 (wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 hrs.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/3, 1958</b> to <b>4/19, 1967</b> , that (I) <del>was</del> lost sow the deceased alive on <b>4/24, 1967</b> , and that death occurred at <b>11:30 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>F. E. Musser</b> M.D.		22b. DATE SIGNED <b>4/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. E. Musser</b>		22d. ADDRESS <b>4410 74th Ave Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/2/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



02620

02620

Prince George's	Chavally	1 hour	Edmonton	Prince George's
Prince George's	Prince George's General Hospital		EDUT. Cf. London 24.	
Charles			April	
White			1958	
			1958	

*Hypercholesterolemia*

*F. E. M. 1958*

*8/3 1958*

*4/24 1958*

*4/24 1958*

MAY 2 1958

Prince George's



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

05631

Item #9 Film #G388 4/25/67 pc

CERTIFICATE OF DEATH

05631

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b> d. STREET ADDRESS <b>4110 - 46th Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Helen - Harris</b>			4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/1988</b>		9. AGE (In years lost birthday) yrs. <b>78 7/9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Bladensburg Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Chase</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Barket</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Charles Harris - 1218 Queen St NE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident - Thrombosis</b> DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonitis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <del>xx</del> (this hospital) attended the deceased from <b>April 1, 1967</b> , to <b>April 14, 1967</b> , that <del>xx</del> (we) last saw the deceased alive on <b>April 14, 1967</b> , and that death occurred at <b>1:15AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Edwin Jensen</b>			22b. DATE SIGNED <b>April 14, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>			22d. ADDRESS <b>Prince Georges General Hospital</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>4-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Charles</b>		23d. LOCATION (City or Town) (County) (State) <b>Northridge Md</b>	
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Son</b>			25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



1332

16260



05632

05632

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>12 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b> d. STREET ADDRESS <b>5345 Addison Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis -- Harris</b>		4. DATE OF DEATH Month Day Year <b>April 5, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1918</b>
9. AGE (In years last birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Way County N.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>US.</b>		13. FATHER'S NAME <b>William Ollie Harris</b>	
14. MOTHER'S MAIDEN NAME <b>Mrs. Bessie Williams</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>5345 Addison Rd. Chapel Oaks</b> <b>Mrs. Blannie M. Harris</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 5400 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive upper GI. bleeding</b> DUE TO (c) <b>Strenuous gastric ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 24, 1967</b> , to <b>April 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 5, 1967</b> , and that death occurred at <b>2:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>D.S. Banisadr</b>		22b. DATE SIGNED <b>April 5, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Amir Banisadr, M.D.</b>		22d. ADDRESS <b>6323 Landover Rd., Cheverly, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-10-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Ra leigh, N.C.</b>
24. FUNERAL DIRECTOR <b>John T. Rhee</b>		ADDRESS <b>3015 12th St. N.E. D.C.</b>	25a. REC'D BY REGISTRAR DATE <b>APR 13 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05633		05633	
1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5905 Lee Place	
3. NAME OF DECEASED (Type or print) First Middle Last Charles D. Harrison		4. DATE OF DEATH Month Day Year April 21, 19 67	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/27/98	
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bakers Helper	
11. BIRTHPLACE (County & State, or foreign country) Prince George's Co Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Harrison		14. MOTHER'S MAIDEN NAME Annie Stephenson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. —	
17. INFORMANT Frances Harrison		Address Same as 2 D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO (b) Carcinoma of lung DUE TO (c) Pancreatic tumor		INTERVAL BETWEEN ONSET AND DEATH Aug. 1966 Apr. 1967	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy & cystitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan, 1967, to Apr. 21, 1967, that (I) (we) lost saw the deceased alive on 21 Apr 19 67, and that death occurred at 8:25 M. from causes on and on the date stated above.		22a. SIGNATURE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> PM 22b. DATE SIGNED 22 Apr 67	
22c. PHYSICIAN'S NAME (Type) Ronald P. Hairston, M. D.		22d. ADDRESS 3302 Hayes St. Glenarden Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-26-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet		23d. LOCATION (City or Town) (County) (State) Wash N.C.	
24. FUNERAL DIRECTOR H-S. Washington & Sons		ADDRESS 4925 Deane Ave	
25a. REC'D BY REGISTRAR DATE APR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

73

1. PLACE OF DEATH a. COUNTY PG. Riverdale, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY PG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,		c. LENGTH OF STAY IN 1b 16 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 5217 Newton Street, 161	
3. NAME OF DECEASED (Type or print) First Middle Last Wilma Ethel Harvey		4. DATE OF DEATH Month Day Year April 17 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1914
9. AGE (In years last b. day) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.	
11. BIRTHPLACE (County & State, or foreign country) N-Carolina		12. CITIZEN OF WHAT COUNTRY? Amer	
13. FATHER'S NAME XX James M. Hicks		14. MOTHER'S MAIDEN NAME XX Bessie Deathridge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Eugene Leland Hospital, 4408 Queensbury Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 4201 VENTRICULAR FIBRILLATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO ACUTE MYOCARDIAL INFARCTION (c)		INTERVAL BETWEEN ONSET AND DEATH 45 MIN 15 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-2, 1967, to 4-17, 1967, that (I) (we) last saw the deceased alive on 4-17, 1967, and that death occurred at 7:30 p.m., from causes and on the date stated above.			
22a. SIGNATURE C.J. HOUmann		22b. DATE SIGNED 4-17-67	
22c. PHYSICIAN'S NAME (Type) C.J. HOUmann		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/21/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland		25a. REC'D BY REGISTRAR APR 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>District Of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>1336 Ridge Place, S.E.</b>	
3. NAME OF DECEASED (Type or print) <b>Walter Nelson Hicks, Jr.</b>		4. DATE OF DEATH Month <b>4</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5-22-1942</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
13. FATHER'S NAME <b>Walter N. Hicks, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Miriam Nunemaker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-58-3021</b>	
17. INFORMANT <b>Elizabeth Childs-Aunt</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>Skull fracture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in collision.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>10:30pm</b> 4-26-1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>US Rt. 1, 1 1/2 mile so. of Annendale Rd.</b>	20f. (City or town) <b>Beltsville, Md.</b> (County) <b>PG</b> (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-27-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>	
ADDRESS <b>Washington, D. C.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05636

05636

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>21 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2000 Ravenswood Street</u>		d. STREET ADDRESS <u>2000 Ravenswood St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>FRANCIS</u> Last <u>HOGAN, SR.</u>		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Torrington, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PATRICK HOGAN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE GLASHEEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>041-10-1855</u>	
17. INFORMANT <u>Dorothy K. Hogan</u>		Address <u>2000 Ravenswood St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Prostate</u> DUE TO (c) <u>metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>April 1967</u> , that (I) <u>met</u> last saw the deceased alive on <u>Apr. 5</u> 19 <u>67</u> , and that death occurred at <u>12</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>4-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 Univ. Blvd E, SIL. SP. MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town, or county) (State) <u>Silver Spring, Montgomery Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>APR 10 1967</u>	
ADDRESS <u>Hyattsville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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CERTIFICATE OF LEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05637

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>	
c. LENGTH OF STAY IN 1b <b>hours</b>		d. STREET ADDRESS <b>3714 Shepherd Street.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B&amp;O Railroad, 225 ft. south of mile post</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Curtis Howard</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 May 1925</b>
9. AGE (In years last birthday) yrs. <b>41</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wollman Howard</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Lopper</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-22-5231</b>	
17. INFORMANT <b>Mr. Wollman Howard - Dr., College Pk.</b>		Address <b>7323-Radcliff</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Evisceration</b> DUE TO <b>From trauma - struck by railroad train.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Struck by railroad train.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by railroad train.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:30am</b> <b>4-22-</b> <b>19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>B&amp;O Railroad, 225 ft. south of mile post 3410</b>		20f. (City or town) (County) (State) <b>Brentwood, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-24-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/25/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Com.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Malloy's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 26 1967</b>	
ADDRESS <b>Mt. Rainier, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05638

05638

FOR STATE HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.  
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		16c	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's Hospital</b>				d. STREET ADDRESS <b>4550 Ammandale Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Randy Gene Ingram</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1965</b>	9. AGE (In years last birthday) <b>2</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Takoma Park Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HOMER W. INGRAM</b>				14. MOTHER'S MAIDEN NAME <b>BETTY JEAN LINGER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT Address <b>Same as</b> <b>Mr. Homer W. INGRAM, H 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 432.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis</b> DUE TO (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>  <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>				22. DATE SIGNED <b>2-29-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Riverdale, Md.</b>			
23a. BURIAL CREMATION APPROVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Apr 30, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bell Valley Cem</b>		23d. LOCATION (City or town) (County) (State) <b>CRIGSVILLE, VA</b>	
24. FUNERAL DIRECTOR <b>Harold S Wade, Laurel, Md</b>				25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05639

05639

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale,</b>		c. LENGTH OF STAY IN lb <b>13 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		161	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		d. STREET ADDRESS <b>7440 Dangerfield Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Luther</b> Middle <b>A.</b> Last <b>Irby</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-6-11</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>22</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Transfer Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Andrews Air</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Henry Irby</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Switzerlet</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Admitting Record</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>General arterio-sclerosis</b> DUE TO (c) <b>undetermined</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 9</b> , 19 <b>67</b> , to <b>Apr 24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Apr 21</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>LWM</b>		22b. DATE SIGNED <b>4-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LWM &amp; Irby MD</b>		22d. ADDRESS <b>Riverdale, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-24-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEMORIAL</b>	23d. LOCATION (City or Town) (County) (State) <b>WALDORF CHARLES, MD.</b>
24. FUNERAL DIRECTOR <b>The HUNT FUNERAL HOME, WALDORF, MD.</b>		25a. REC'D BY REGISTRAR <b>APR 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05640

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05640

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		d. STREET ADDRESS <b>713 Chillum Rd., Apt. 101</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arthur F. Jefferson</b>		4. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-21-1934</b>
9. AGE (In years lost birthday) yrs. <b>32</b>		10. CITIZEN OF WHAT COUNTRY <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Arthur F. Jefferson, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Ruth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ruth Phillips (Mother)</b>		Address <b>713 Chillum Rd Hyattsville, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>Strangulation by hanging</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Hung self with shirt tied to top of door.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>about 3:30am 4-18-67</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3:30am</b> p.m. <b>4-18-67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cell, Hyattsville Jail, Hyattsville, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kenoe</b>		22. DATE SIGNED <b>4-18-67</b>	
EXAMINER'S NAME (Type) <b>John Kenoe, M.D. Riverdale, Md.</b>		23. BURIAL, CREMATION, REMOVAL (Specify) <b>April 22-1967</b>	
23b. DATE THEREOF <b>April 22-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lawrence</b>	
23d. LOCATION (City or Town) (County) (State) <b>Beltsburg Rd P. Co. Md</b>		24. FUNERAL DIRECTOR <b>Arthur Walters</b>	
24b. ADDRESS <b>254 Carroll St</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	
25a. DATE <b>APR 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05641

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05641

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> 16.1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>11342 Cherry Hill Road</b>			
3. NAME OF DECEASED (Type or print) <b>Magdalena</b>				4. DATE OF DEATH Month <b>4</b> Day <b>9</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 July 1892</b>		9. AGE (In years lost birthday) yrs. <b>74</b>	10. IF UNDER 1 YEAR Months <b>4</b> Days <b>9</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cuba</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Pedro DeArmas</b> <b>Beltsville, Md.</b> <b>11342 Cherry Hill Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Hypertensive arteriosclerotic heart disease</b> over 15 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b> <b>Riverdale, Md.</b>				22. DATE SIGNED <b>4-10-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/12/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <i>W. Ernest Jarvis</i> <b>W. Ernest Jarvis Co., Inc.</b>				25a. REC'D BY REGISTRAR <b>APR 13 1967</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



05441

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Business hours: 9:00 a.m. to 5:00 p.m.

Address:

City:

State:

Phone:

Telex:

Person:

Organization:

Age:

Sex:

Occupation:

Education:

Religion:

Known:

Unknown:

Address:

Phone:

Address:

Phone:

Address:

Phone:

X

X

X

1-10-57

John F. Kennedy, Jr.

Washington, D.C.

Mr. Calvert

1/12/57

1132 You Street, N.W., R. 1, 1957



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05642

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05642

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. LENGTH OF STAY IN lb <b>2 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9309 Rollingview Drive</b>		d. STREET ADDRESS <b>9309 Rollingview Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Alta Mae Johnson</b>		4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 May 1908</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>IOWA</b>	
11. BIRTHPLACE (State or foreign country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HASTIE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWNED</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>JERRY W. JOHNSON</b>		Address <b>10102 52ND AVE. COLLEGE PARK, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>Bronchial asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>days over 10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-26-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		22. DATE SIGNED <b>4-26-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM</b>	23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG MD</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. RIVERDALE, MD.</b>		25a. REC'D BY REGISTRAR <b>APR 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05643

CERTIFICATE OF DEATH

05643

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>			c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE MARYLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>4708 COOPER LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MOLLY</b> Middle <b>GARFIELD</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>19 67</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 APRIL 1882</b>	
9. AGE (In years last birthday) yrs. <b>85</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>NEWCASTLE VIRGINIA</b> <b>CRAIG COUNTY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WILLIAM B DOSS</b>			
14. MOTHER'S MAIDEN NAME <b>ELIZA HUFFMAN</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Darline BUCHANAN</b> <b>DAUGHTER-IN-LAW</b>			
18. ADDRESS <b>4708 COOPER LANE</b> <b>HYATTSVILLE MD</b>				19. INTERVAL BETWEEN ONSET AND DEATH <b>50 MIN</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>CORONARY ARTERIOSCLEROSIS</b> YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>16 APRIL, 1967</b> , to <b>18 APRIL, 1967</b> , that (I) (we) last saw the deceased alive on <b>18 APRIL 19 67</b> , and that death occurred at <b>7:51 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Stephen Podolsky</b>				22b. DATE SIGNED <b>18 APRIL 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>STEPHEN PODOLSKY, CAPT, USAF, MC</b>	
22d. ADDRESS <b>USAF HOSPITAL ANDREWS</b> <b>ANDREWS AFB, WASHINGTON DC 20331</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4/19/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Roanoke, Virginia</b>	
24. FUNERAL DIRECTOR <b>The S. H. Hines Co. Washington D. C.</b>				25. REC'D BY REGISTRAR <b>APR 20 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05644

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05644

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville (Cheverly)</b>			c. LENGTH OF STAY IN lb <b>33 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's Hospital</b>				d. STREET ADDRESS <b>7348 Landover Rd. Apt. E</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clinton Ray Jordan</b>				4. DATE OF DEATH Month Day Year <b>April 30 19 67</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 February 1965</b>		
9. AGE (In years lost birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert R. Jordan</b>				14. MOTHER'S MAIDEN NAME <b>Renee Dousset</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Mr. Robert R. Jordan (above address)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decerebrate rigidity (Father)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Brain stem injury</b> DUE TO (c) <b>Trauma-fall from apartment balcony</b>							INTERVAL BETWEEN DEATH AND DEATH <b>33 hours</b> <b>33 hours</b> <b>33 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from third story balcony of apartment building.</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>5:30 PM 4-28-67 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office, bldg., etc.) <b>same as 2 Home</b>		
20f. (City or town) (County) (State) <b>Hyattsville Prince George's Md.</b>								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John Kehoe</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				22. DATE SIGNED <b>4-30-67</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/4/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nelson Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Nelson, Nebraska</b>		
24. FUNERAL DIRECTOR <b>Valley's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 3 1967</b>		
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05645

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05645

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D O A</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>Route 94</b>	
3. NAME OF DECEASED (Type or print) <b>Susan</b> First Middle Last <b>Priscilla Kachelries</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1887</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Dolan Smith</b>		14. MOTHER'S MAIDEN NAME <b>Hulga Levan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>187 03 0292</b>	
17. INFORMANT <b>W. Jean Kachelries</b>		Address <b>Woodbine, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive Heart failure</b> DUE TO (c) <b>Hypertensive C V Disease</b> 4 years			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>no</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dayton Onatkins</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>DAYTON ONATKINS</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 8, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

22. DATE SIGNED  
**4-7-67**



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05646

# CERTIFICATE OF DEATH

05646

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM, MD</u>		c. LENGTH OF STAY IN lb <u>6 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WAGNOLIA GARDENS Nursing Home</u>		d. STREET ADDRESS <u>1604 Q St NW</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>E</u> Last <u>KAISER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN KAISER</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Geier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK</u>	
17. INFORMANT <u>MR Myer</u>		Address <u>2659 Conn Cir NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>Branchiopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CVA (Cerebral Thrombosis)</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1966</u> , to <u>Apr. 1967</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>APRIL 14</u> 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas G. Maloney</u>		22b. DATE SIGNED <u>4/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas G. Maloney</u>		22d. ADDRESS <u>4714 71st Ave Brookhaven, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST MARY'S</u>	23d. LOCATION (City or Town) (County) (State) <u>WASH DC</u>
24. FUNERAL DIRECTOR <u>Shirley Funeral Home</u>		25a. RECD BY REGISTRAR DATE <u>APR 17 1967</u>	
ADDRESS <u>3605 18th St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



34320

2230



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>FAIRFAX</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US AIR FORCE HOSPITAL ANDREWS</b>		d. STREET ADDRESS <b>3708 Morningside Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>(NMN)</b> Last <b>KAUCH</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 July 1894</b>
9. AGE (In years lost birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US AIR FORCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US AIR FORCE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PHILADELPHIA, PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN KAUCH</b>		14. MOTHER'S MAIDEN NAME <b>ELLA REINER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 30 June 1948</b>		16. SOCIAL SECURITY NO. <b>231-58-4375</b>	
17. INFORMANT <b>WIFE</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROSIS OF CORONARY ARTERIE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>6 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>4 April, 1967</b> to <b>7 April, 1967</b> , that (X) (we) last saw the deceased alive on <b>7 April, 1967</b> , and that death occurred at <b>2:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles D. Phelps</i>		22b. DATE SIGNED <b>7 April 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES D. PHELPS, CAPT USAF MC</b>		22d. ADDRESS <b>USAF Hosp Andrews Andrews AFB, Wash DC 20331</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11 Apr 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <i>David V. Crandall</i> <b>Everly Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>APR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G388 1/26/67

CERTIFICATE OF DEATH

05648

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY <b>n/a</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>30 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>4498 McArthur Blvd. N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>G.</b> Last <b>Kerrigan</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5/30/86</b>		9. AGE (In years last birthday) <b>81 80 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired (War Dept.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Providence R.I.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Edward Kerrigan</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Infarction, Right temporal lobe</b> 332X DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>April 12, 1967</b> , to <b>April 13, 1967</b> , that (I) (we) lost saw the deceased alive on <b>April 13, 1967</b> , and that death occurred at <b>12:45 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Oliver B. Bond</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. PM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Oliver B. Bond, M.D.</b>				22d. ADDRESS <b>6872 Riverdale Rd. Lanham, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash. D.C.</b>	
24. FUNERAL DIRECTOR <b>Hanson Funeral Home</b>				ADDRESS <b>4344 Wisconsin Ave. N.W.</b>		25a. REC'D BY REGISTRAR <b>APR 19 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05649

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05649

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>3809 Volta Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Ashby Kidwell</b>				4. DATE OF DEATH Month Day Year <b>4 13 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 June 1893</b>		9. AGE (In years lost birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during the working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U of Md</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John F. Kidwell</b>				14. MOTHER'S MAIDEN NAME <b>Susan B Campbell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 07 8579A</b>		17. INFORMANT <b>Milburn Florence</b>		Address <b>Washington D. C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.				22. DATE SIGNED <b>4-14-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		<b>Riverdale, Md.</b>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F; Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 18 1967</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05650		CERTIFICATE OF DEATH				05650			
1. PLACE OF DEATH COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE			c. LENGTH OF STAY IN lb 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORRESTVILLE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS					d. STREET ADDRESS 1312 ALBERTA DRIVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROY Middle FRANKLIN Last KIMBLE					4. DATE OF DEATH Month APRIL Day 20 Year 1967				
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 JUNE 1921		9. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE			10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (County & State, or foreign country) LEECO, KENTUCKY			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY KIMBLE					14. MOTHER'S MAIDEN NAME FLOSSIE E. ASH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. APR 51-JUN 67 235-24-3613		17. INFORMANT WIFE		Address SAME AS #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (he) (this hospital) attended the deceased from 2 April 1967, to 20 April 1967, that (he) (we) last saw the deceased alive on 20 April 1967, and that death occurred at 8:40 A.M. from causes on and on the date stated above.									
22a. SIGNATURE Robert R. Mitchell					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 20 APR 67	
22c. PHYSICIAN'S NAME (Type) ROBERT R. MITCHELL, CAPT USAF MC					22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/25/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland					25a. REC'D BY REGISTRAR DATE APR 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



MAKING STATEMENT OF WORK  
ON THE 15th DAY OF APRIL 1964, I, THE UNDERSIGNED, HAVE BEEN ADVISED BY THE  
OFFICE OF THE SECRETARY OF DEFENSE, WASHINGTON, D.C.

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OFFICE OF THE SECRETARY OF DEFENSE

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OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C.

WASHINGTON, D.C.

15 APR 1964

15 APR 1964

STATE OF TEXAS

STATE OF TEXAS

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05651

CERTIFICATE OF DEATH

05651

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5317 Chesapeake St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marion Mae Kraus</b>		4. DATE OF DEATH Month Day Year <b>April 23, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/4/04</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NURSE</b>	11. BIRTHPLACE (County & State, or foreign country) <b>PENNA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN T. THOMAS</b>	
14. MOTHER'S MAIDEN NAME <b>ELEANOR E. GRANT</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>RUTH E. FOSTER 4604 KANSAS AVE. N.W. WASH. D.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Congestive Heart Failure</b> DUE TO (b) <b>Coronary Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that <del>this</del> (this hospital) attended the deceased from <b>April 13, 1967</b> , to <b>April 23, 1967</b> , that (it) (we) last saw the deceased alive on <b>April 23, 1967</b> , and that death occurred at <b>10:50M</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>April 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>4/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>
23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGES, MARYLAND</b>		24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>	
25a. REC'D BY REGISTRAR <b>APR 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



05651

05651

CERTIFICATE OF DATA

Patient Name		Date of Birth		Sex	
Address		City		State	
Occupation		Education		Religion	
Marital Status		Previous Illnesses		Allergies	
Present Illness		History of Present Illness		Physical Examination	
Laboratory Tests		X-ray		Pathology	
Treatment		Prognosis		Follow-up	
Signature of Physician		Signature of Patient		Signature of Nurse	
Date		Time		Place	



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05652 CERTIFICATE OF DEATH 05652											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>						d. STREET ADDRESS <b>6602 VELTRI DRIVE</b>					
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>BYRD</b> Last <b>KREIS</b>						4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>1967</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 OCT 71</b>		9. AGE (In years last birthday) <b>95</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BLAND CO. VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>PHILIP ANDERSON</b>						14. MOTHER'S MAIDEN NAME <b>ELIZABETH BLAND</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>233 09 5987A</b>		17. INFORMANT <b>Son</b>		Address <b>Same as 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CENTRAL NERVOUS SYSTEM INVOLVEMENT</b> DUE TO (c) <b>SEVERE MALNUTRITION AND DEHYDRATION</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>27 APRIL</b> , 19 <b>67</b> , to <b>28 APRIL</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>28 APRIL</b> , 19 <b>67</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <i>David C. Langdon</i> <b>Attended USAF M.E.</b>						22b. DATE SIGNED <b>28 APRIL 67</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN SIMONATTIS, MAJ, USAF, MC</b>		22d. ADDRESS <b>USAF HOSP ANDREWS AFB WASH DC 20331</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>5/1/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MONTICELLO PARK</b>		23d. LOCATION (City, town or county) (State) <b>BLUEFIELD, W. VA.</b>			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO. INC. WASHINGTON DC</b>						25a. REC'D BY REGISTRAR <b>MAY 4 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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## CERTIFICATE OF DEATH

05653

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN lb <b>13 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>RFD, Box 4570</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Albert F. Labrecque</b>				4. DATE OF DEATH Month Day Year <b>April 21, 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 9, 1892</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.I</b>		16. SOCIAL SECURITY NO. <b>029-01-2386A</b>		17. INFORMANT <b>George A. La Brecque</b> <b>2214 Olson Court Marlow Hgts. Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA (Cerebral Vascular Accident)</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial infarct</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>Jan</b> , 19 <b>66</b> , to <b>April 21</b> , 19 <b>67</b> , that (I) <del>was</del> last saw the deceased alive on <b>April 21</b> , 19 <b>67</b> , and that death occurred at <b>8:25 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>A. Clark Holmes</b>				22b. DATE SIGNED <b>4/21/67</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M.D.</b>				22d. ADDRESS <b>4108 Pratt St., Upper Marlboro, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monson, Mass.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc. Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>APR 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



05853

STATE OF TEXAS

05853

James H. Hays

James H. Hays

James H. Hays

James H. Hays

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James H. Hays



CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General</u>				d. STREET ADDRESS <u>5705 31st ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Mary T. Laycock</u>				4. DATE OF DEATH <u>April 1 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-1899</u>		9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>apt House</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James Heale</u>			
14. MOTHER'S MAIDEN NAME <u>Annie Sanford</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>579-32-9944 Catharine Cole 5-705-3101 Ave Hyattsville</u>			
16. SOCIAL SECURITY NO. <u>579-32-9944</u>				17. INFORMANT <u>Catharine Cole</u> Address <u>5705-3101 Ave Hyattsville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of ovary</u> DUE TO (b) <u>Carcinoma of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>breast</u> Interval between onset and death <u>breast</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MARCH 13</u>	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 13 1967</u> to <u>April 1 1967</u> , that (I) (we) lost saw the deceased alive on <u>April 1 1967</u> , and that death occurred at <u>6:55 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitsky</u>				22b. DATE SIGNED <u>4/3/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky</u>				22d. ADDRESS <u>3408-91st Ave N.W. Gaines, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4-5-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wash. D.C.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



05024

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

05024

Princk (Mrs) (deceased)  
Age 31 years  
Born April 1, 1894  
New York City  
Cause of death: ...  
Date of death: ...  
Place of death: ...  
Signature: ...  
Date: ...



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VR A15 (4)  
20 M 1/66

7 1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05655

CERTIFICATE OF DEATH

05655

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Caeverly</b>		c. LENGTH OF STAY IN 1b <b>31 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> 16-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>(Vincents Trailer Ct.) 3200 Kenilworth Ave.</b> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William N Lemmons</b>		4. DATE OF DEATH Month Day Year <b>8 April 4 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 May 1906</b>
9. AGE (In years lost birthday) <b>60</b> yrs.		10. IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Detective</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lester A. Lemmons</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Jane Blanton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>213 12 1815</b>	
17. INFORMANT <b>Dorothy I. Lemmons</b> Address <b>Same as #2 (wife)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>16-21</b> <b>Brain aneurysm</b> DUE TO (b) <b>4 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/4/67</b> , to <b>4/4/67</b> , that (I) (we) last saw the deceased alive on <b>4/3/67</b> , and that death occurred at <b>7:00A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>F E M U S S E R</b> M.D.		22b. DATE SIGNED <b>4/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F E M U S S E R</b>		22d. ADDRESS <b>4410 24th Ave Beltsville Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/6/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>



052525

052030

2000: 13

2760 JGIM

(1) (a) *John is a doctor.*

...and ...

continued

UNIVERSITY OF CALIFORNIA, BERKELEY



OK by Dr John Kehoe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05656 CERTIFICATE OF DEATH 05656									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Mem. Hosp.					d. STREET ADDRESS 11630 - 36th Pl.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence		First Middle Last P. T. Lockhart		4. DATE OF DEATH April 13, 1967		Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1916	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bell Vending Machine		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard T. Lockhart				14. MOTHER'S MAIDEN NAME Minnie E. Orndorff					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-01-1771		17. INFORMANT Mrs. Mary H. Lockhart (above address)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4301 Coronary Thrombosis, ACUTE DUE TO (b) Anteroseclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/25 4:54 PM to 4/13, 1967, that (I) (we) last saw the deceased alive on 4/4 1967, and that death occurred at A.M., from the causes and on the date stated above.									
22a. SIGNATURE Norman D. Concan		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/14/67	
22c. PHYSICIAN'S NAME (Type) Norman D. Concan		22d. ADDRESS 3503 Pennys Mt Rainier Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Com.		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier Maryland		REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
APR 17 1967									



32250

05220



## CERTIFICATE OF DEATH

05657

05657

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>4810 TILINOS AVE NW</u> b. COUNTY <u>Washington DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton md</u>		c. LENGTH OF STAY IN 1b <u>8 hrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>		d. STREET ADDRESS <u>4810 TILINOS AVE NW</u>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Md General Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4/23/25</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>us govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cincinnati Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM C. BELL</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN COATES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>2805 MONROE, N.E.</u>	
17. INFORMANT <u>LILLIAN RUTHERFORD WASH., D.C.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory Embarrassment</u> DUE TO (c) <u>Marked Distension of Small Bowel Obstruction</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> , 19 <u>67</u> , to <u>4/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Steven Cristian MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>STEVEN CRISTIAN MD</u>		22d. ADDRESS <u>1534 16th St NW Washington DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4.26.67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR <u>McCounes Funeral Service</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed with the signature of the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and forward it to the State Department of Health, 301 W. Preston Street, Baltimore, Maryland 21201.



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12552

NO RECORDING REQUIRED

ALM. RECORDING REQUIRED

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APR 2 1951

Y. T. Y.

Y. T. Y.



05658

CERTIFICATE OF DEATH

05658

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN lb <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>4417 Tonquil St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>E.</b> Last <b>Lowe</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/94</b>	9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>WILLIAM THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>LUCY PURNELL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579 09 4377</b>		17. INFORMANT <b>MRS MARYC. DOLAN</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism fatal</b> <b>5721</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>PERIPHERIC BACERY Left</b> (c) <b>Pulmonary infarction left immediate</b> <b>Pneumonia 2° ruptured diverticula sigmoid</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> , 19 <b>67</b> , to <b>4/7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>April 7</b> , 19 <b>67</b> , and that death occurred at <b>1:10A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Albert Roth</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Albert Roth, M. D.</b>				22d. ADDRESS <b>5409 Riverdale Rd., Riverdale, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-10-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FLINCOLN CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS Co. RIVERDALE, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05055

OFFICE OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

05659

CERTIFICATE OF DEATH

05659

1. PLACE OF DEATH a. COUNTY <i>Prince Georges County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>12 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		16/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1905 Erie Street</i>				d. STREET ADDRESS <i>1905 Erie Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>(nni)</i> Last <i>Lynch</i>				4. DATE OF DEATH Month <i>Apr</i> Day <i>24</i> Year <i>1967</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov 21, 1889</i>		9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Claims Examiner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Air Force</i>		11. BIRTHPLACE (County & State, or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William P. Lynch</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Mc Keever</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO. <i>578-32-4863-A</i>		17. INFORMANT <i>Mrs. Mary Lynch</i> Address <i>1905 Erie Street Hyattsville, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201 Coronary Heart Disease</i> DUE TO (b) <i>Arteriosclerosis Generalized</i> DUE TO (c) <i>15 yrs.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>7 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1946</i> , 19 <i>30</i> to <i>4/24/67</i> , 19 <i>30</i> , that (I) (we) last saw the deceased alive on <i>19 Apr 1967</i> <i>1946</i> , and that death occurred at <i>11 PM</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/25/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>G. B. Queen</i>				22d. ADDRESS <i>344 University Blvd. W., S. S., Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 28, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Alexandria Nat'l Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Alexandria Virginia</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas Warner E. Humphrey, Inc.</i>				ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 28 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



05650

CERTIFICATE OF DEATH

05650

George Joseph

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VR A15ME (5)  
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b> c. LENGTH OF STAY IN ID <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Paint Branch Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Adelphi unknown</b> d. STREET ADDRESS <b>3120 Powder Mill Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>John A. Mahan</b>					4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 2, 1893</b>		9. AGE (in years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Mahan</b>					14. MOTHER'S MAIDEN NAME <b>Agnes B. O'Connell</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>579-10-3022</b>		17. INFORMANT Address <b>Paint Branch Nursing Home Records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		2Dc. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Kehoe MD</b>					22. DATE SIGNED <b>5-1-67</b>				
EXAMINER'S NAME (Type) <b>John Kehoe M.D.</b>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-2-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Landover, Md.</b>		
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



05000

Medical Exam. & Cert. Date of Death

05000

100-100000

George's, Maryland, George's

Additional, Medical

2100-100000, 1000-100000, 1000-100000

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN TB <u>34 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>5800 64th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Carrie R. Martin</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>April 7, 1967</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4/14/99</u>
<b>9. AGE</b> (In years last birthday) yrs. <u>67</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William A Fawcett</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice May Keene</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> 	
<b>17. INFORMANT</b> <u>George Carrick</u>		<b>Address</b> <u>Riverdale, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emboli</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			<b>INTERVAL BETWEEN ONSET AND DEATH</b> 
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension Left Kidney</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State) 			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July</u> , 19 <u>66</u> , to <u>4/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:25 AM</u> , from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>William D. Rosson MD</u>		<b>22b. DATE SIGNED</b> <u>4/7/67</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. William D. Rosson</u>		<b>22d. ADDRESS</b> <u>5701 85th Ave., Hyattsville, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>April 10, 1967</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>23d. LOCATION (City or Town)</b> (County) (State) <u>Suitland Pro Geo Md.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>F. Gasch's Sons</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 10 1967</u>	
<b>ADDRESS</b> <u>Hyattsville, Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Judge</u>	



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2010 年 12 月 25 日



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05662

05662

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>District of Columbia</b> <i>Pr. George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> <i>16.1</i>		d. STREET ADDRESS <b>1216 61st Ave., S.E.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>B.</b> Last <b>McAfee</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/96</b>
9. AGE (In years) <b>71</b> (lost birthday) yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles McAfee</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Same As # 2</b>	
17. INFORMANT <b>Abbie H. McAfee</b>		Address <b>Same As # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Pulmonary Edema</b> <b>5272</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>April 14, 1967</b> , to <b>April 15, 1967</b> , that (we) last saw the deceased alive on <b>April 15, 1967</b> , and that death occurred at <b>12:40 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Laurence J. Lieberman</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>APRIL 15, 1967</b>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Maryland</b>
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b>		ADDRESS <b>4308 Southland Rd. Southland Md</b>	25a. REC'D BY REGISTRAR <b>APR 19 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05002

Princess George's

General

1 day

Washington, D.C.

Princess George's General Hospital

1215 First Ave.

John

H.

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Princess George's

General

1 day

1 day

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1 day

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1 day

1 day

1 day

1 day



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05663

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05663

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN Ib <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gladys A. McClanahan</b>		4. DATE OF DEATH Month Day Year <b>4 17 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-16-96</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HETLIN</b>		14. MOTHER'S MAIDEN NAME <b>ISABELLE VOGT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-05-8889A</b>	
17. INFORMANT <b>MRS. EUNICE NASHWINTER</b>		Address <b>CATLETT, VA.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 2 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>4-18-67.</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>APRIL 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR RUN CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>SOUEGO, VA.</b>
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO. RIVERDALE, MD.</b>		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05664

05664

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. LENGTH OF STAY IN lb <u>2 WEEKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REGENT NURSING HOME</u>		d. STREET ADDRESS <u>624 NORTH WASHINGTON ST</u>	
3. NAME OF DECEASED (Type or print) <u>PATRICK H. McCloskey</u>		4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 3, 1905</u>
9. AGE (In years lost birthday) yrs. <u>62</u>		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAREHOUSE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW CASTLE, ENG</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES MC CLOSKEY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET UNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>167 12 7177</u>	
17. INFORMANT <u>TERESA FLYNN</u>		Address <u>5951 NORWOOD ST Phila Pa</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic melanoma to brain</u> DUE TO (b) <u>Melano Carcinoma of the Left Neck</u> DUE TO (c) <u>5 YRS.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <u>MAR 1, 1967</u> , to <u>APR 14, 1967</u> , that (H) (we) last saw the deceased alive on <u>APR 14, 1967</u> , and that death occurred at <u>3:06 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W B Sheer</u>		22b. DATE SIGNED <u>4-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER M.D.</u>		22d. ADDRESS <u>6400 MARLBORO PIKE S.E. WASH. D.C. 20028</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ALEXANDRIA NATL</u>	23d. LOCATION (City or Town) (County) (State) <u>ALEXANDRIA, VA</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers Co. Inc</u>		25a. REC'D BY REGISTRAR <u>APR 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



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05665

## CERTIFICATE OF DEATH

05665

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>47.3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN lb <b>7 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Manor</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Josephine A. McDevitt</b>		4. DATE OF DEATH Month Day Year <b>4 20 1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/1/1881</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Smithsonian Institution</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, DC</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McDevitt</b>		14. MOTHER'S MAIDEN NAME <b>Unobtainable</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Carroll Manor Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hemiplegia 8 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 9, 1960</b> to <b>April 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1967</b> , and that death occurred at <b>6 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Collins</b>		22b. DATE SIGNED <b>April 20, 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Collins</b>		22d. ADDRESS <b>322 H St. N.E., Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/22/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>The S. H. Hines Company</b>		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



60220



05666

CERTIFICATE OF DEATH

05667

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>D O A</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>407 Addison Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Michael Joseph McGarry</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 1, 1894</b> 9. AGE (In years last birthday) <b>72</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Patrick McGarry</b>		14. MOTHER'S MAIDEN NAME <b>Julia Carr</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213 38 2218</b>	
17. INFORMANT <b>Anna McGarry</b>		Address <b>Same as #2 (wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY &amp; MYOCARDIAL OCCLUSION INFARCTION</b> DUE TO <b>CORONARY HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <b>HYPERTENSIVE CARDIO-VASC. DISEASE &amp; INTERMITTENT CLAUDICATION</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan - 19 58</b> to <b>Feb - 1967</b> , that (I) (we) last saw the deceased alive on <b>FEB - 4 1967</b> , and that death occurred at <b>1:20 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Max M. Herzberg</b>		22b. DATE SIGNED <b>4-6-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Max M. Herzberg</b>		22d. ADDRESS <b>3308 Dodge Pk. Rd., Landover, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR OATE <b>APR 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05666

05666

STATEMENT OF INCOME

Prince George's  
Chesley  
W.D.A.  
Last Payment  
407 Addition Bond  
Prince George's General Hospital  
George's  
George's

W.D.A.  
Chesley  
W.D.A.  
Last Payment  
407 Addition Bond  
Prince George's General Hospital  
George's  
George's

W.D.A.  
Chesley  
W.D.A.  
Last Payment  
407 Addition Bond  
Prince George's General Hospital  
George's  
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W.D.A.  
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Last Payment  
407 Addition Bond  
Prince George's General Hospital  
George's  
George's

W.D.A.  
Chesley  
W.D.A.  
Last Payment  
407 Addition Bond  
Prince George's General Hospital  
George's  
George's



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05666

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>418 Maurey Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>William A McNab</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1931</b> <b>12-16-1929</b>
9. AGE (In years lost birthday) <b>35</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George E. McNab</b>	
14. MOTHER'S MAIDEN NAME <b>Norma Swartzman</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>N/A</b>	
16. SOCIAL SECURITY NO. <b>579 38 2655</b>		17. INFORMANT <b>George McNab- Bro</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>Trauma - motorcycle accident.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of motorcycle which ran into parked car.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:55pm</b> <b>4-22- 19 67</b>	20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>400 Maurey Ave., Oxon Hill, Md.</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>4-24-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home, 300 4th NE. Wash. DC</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items #1c, 8 & 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

Reg. Dist. No. 05668

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avaldale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avaldale	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4827 Russell Avenue		d. STREET ADDRESS 4827 Russell Avenue	
3. NAME OF DECEASED (Type or print) JAMES J. MCPADDEN SR.		4. DATE OF DEATH April 10 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1 1888
9. AGE (In years, months, days) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truckor		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hugh McPadden		14. MOTHER'S MAIDEN NAME Mary Flynn Flynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Wife		Address 4827 Russell Ave, Hyatts.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Artery Disease. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1967, to April 1967, that I last saw the deceased alive on April 10, 1967, and that death occurred at 2:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11 Apr 67			
ACTUAL SIGNATURE Wm. A. Wimsatt M.D.			
PHYSICIAN'S NAME (Type) William A Wimsatt M.D. 3415 Hamilton Street, Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/67	
22c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) White Plains, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home		24a. REC'D BY REGISTRAR APR 14 1967	
ADDRESS Mt Rainier, Maryland		24b. REGISTRAR'S SIGNATURE Charles Judge	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05663

CERTIFICATE OF DEATH

05669

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anna Arundle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b>		d. STREET ADDRESS <b>Rt. 1 Box 520 Evergreen Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>McVea</b> Last <b>McVea</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 March 1892</b>
9. AGE (In years lost birthday) yrs. <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Cosminer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Peary McVea</b>	
14. MOTHER'S MAIDEN NAME <b>Addie Tate</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mrs Julia McVea</b> Address <b>Baltimore 2 D</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Failure.</b> 592X DUE TO (b) <b>uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>chronic glomerulonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>old myocardial infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>March 20, 1967</b> , to <b>April 3, 1967</b> , that <del>the</del> (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>9:00PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>B. Bahrami</b>		22b. DATE SIGNED <b>4, 4, 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. Bahrami, M.D.</b>		22d. ADDRESS <b>3003 N. 1st St. Rd, S.E., D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>4-5-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Whitman</b>		23d. LOCATION (City or Town) (County) (State) <b>Logan West Virginia</b>	
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Son</b>		25. REGISTRATION BY REGISTRAR <b>APR 5 1967</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		27. REGISTRAR'S SIGNATURE	



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James Hamilton

Mar. 1900

James Hamilton

London

19 days

Cherry

RE. I. Box 300, New York City

Edinburgh General Hospital

Nov. 1900

Nov. 1900

Nov. 1900

19 March 1900

19 March 1900

19 March 1900

RE. I. Box 300, New York City  
Edinburgh General Hospital  
Nov. 1900  
19 March 1900

RE. I. Box 300, New York City  
Edinburgh General Hospital  
Nov. 1900  
19 March 1900

RE. I. Box 300, New York City  
Edinburgh General Hospital  
Nov. 1900  
19 March 1900



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

Item# 3,111-6469 3/12/74 kam		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
05670		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights</b>	
c. LENGTH OF STAY IN lb <b>DOA</b>		d. STREET ADDRESS <b>907 60th. Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Agnes Minnis</b>		4. DATE OF DEATH Month <b>4</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 Nov. 1914</b>	
9. AGE (In years lost birthday) yrs. <b>52</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Burley</b>		14. MOTHER'S MAIDEN NAME <b>Annie Harrison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-54-1427</b>	
17. INFORMANT <b>Elizabeth Marshall</b>		Address <b>Fairmont Hgts 907-60th Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Hypertensive arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-10-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-15-67</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>Highland Park Md</b>	
24. FUNERAL DIRECTOR <b>H. S. Washington Sons</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>	
ADDRESS <b>4925 DEANE AVE NE</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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05270

1. The first of these is the fact that the

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the third is the fact that the

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the seventeenth is the fact that the

the eighteenth is the fact that the

APR 17 1967



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05671

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> 16.1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>8122 Redwood Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Earl Dykes Meunier</b>			4. DATE OF DEATH <b>4 7 19 67</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-22</b>		9. AGE (In years lost birthday) yrs. <b>45</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Meunier</b>			14. MOTHER'S MAIDEN NAME <b>Genevieve Dykes</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Katheryn R. Meunier</b> Address <b>Same As # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>over 2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe M.D., Riverdale, Maryland</b>				22. DATE SIGNED <b>4-8-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



1732

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527-528



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

05672

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05672

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>7 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>2020 32nd. St., S.E.</b>	
3. NAME OF DECEASED (Type or print) <b>Mamie B Meyer</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-1878</b>
9. AGE (In years lost birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H Brewer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ward</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Harryett Crump. same as 2.D</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of left hip.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Fell at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:40pm</b> m. <b>4-15- 1967</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20e. (City or town) (County) (State) <b>same as #2</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>4-24-67</b>	
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		<b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4.26.67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home. 300.4th st N E</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05673

CERTIFICATE OF DEATH

05673

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.				d. STREET ADDRESS 913 Jackson Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marguerite C. Middle Last Moore				4. DATE OF DEATH Month April Day 16 Year 19 67			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1891	
				9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legal work				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.	
						12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Richard F. Moore				14. MOTHER'S MAIDEN NAME Mary A. Rodgers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown				16. SOCIAL SECURITY NO. 578-62-2462		17. INFORMANT Sacred Heart Home, Hyattsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4200</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 12</u> , 19 <u>66</u> , to <u>April 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 16</u> , 19 <u>67</u> , and that death occurred at <u>7:45 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>John F. Brennan Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) John F. Brennan, Jr. M.D.				22d. ADDRESS 1034 Perry St., Washington, D.C. 20017			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Wash., D.C.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR APR 20 1967	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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1999 • J. Neurosci., November 10, 1999 • 19(22):9101–9111 • 9101

Soils 5-35



CERTIFICATE OF DEATH

05674

05674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>FAUQUIER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>9 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR 4922 HASSELL RD.</u>				d. STREET ADDRESS <u>418 WINCHESTER ST.</u>			
3. NAME OF DECEASED (Type or print) <u>GERALDINE L MORSE</u>				4. DATE OF DEATH <u>APRIL 9 1967</u>			
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-1886</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>ST. CLOUD, MINN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Everett H. Morse</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn C. Horrigan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Dr. Christine Carroll Manor</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (1) (this hospital) attended the deceased from <u>4/6</u> , 19 <u>67</u> , to <u>4/8</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>67</u> , and that death occurred at <u>5 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John W. Winkler Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN W WINKLER JR</u>				22d. ADDRESS <u>5800 10th RD HYATTSVILLE MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Warrenton Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Warrenton VA.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>				25a. REC'D BY REGISTRAR <u>3004 ST NE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>APR 11 1967</u>							



05674

05674

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11-11-88 BY 1043  
EXCEPT WHERE SHOWN OTHERWISE

APR 11 1989



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

05675

CERTIFICATE OF DEATH

05675

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>2345 Bellevue Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE Lee Moyer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1881</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13. FATHER'S NAME <u>James Moyer</u>		14. MOTHER'S MAIDEN NAME <u>---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-22-9382</u>	
17. INFORMANT <u>Nursing home records</u>		Address <u>Same as #1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4200</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>  <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>66</u> , to <u>4/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>67</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitsky</u>		22b. DATE SIGNED <u>4/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky M.D.</u>		22d. ADDRESS <u>3408 Rhode Island Ave. Mt. Rainier, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Leesburg Va.</u>
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1552



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05676

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05676

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>		c. LENGTH OF STAY IN lb <b>24 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> 16-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>25 Andrews Air Force Base Hospital</b>				d. STREET ADDRESS <b>6-14 Cedarville Trailer Ct.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Donald D. Mulcahy</b>				4. DATE OF DEATH Month Day Year <b>April 30 19 67</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 Feb. 1935</b>		9. AGE (In years last birthday) <b>32 yrs.</b>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MM-1 SAILOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		11. BIRTHPLACE (State or foreign country) <b>WISCONSIN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RAYMOND STEVEN MULCAHY</b>				14. MOTHER'S MAIDEN NAME <b>IRENE HANNAH DOLSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>389-32-0231</b>		17. INFORMANT <b>VERDA N. MULCAHY</b>		Address <b>SAME AS 2 D</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> 8214 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Multiple skull fractures</b> DUE TO (c) <b>Trauma - motorcycle accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>24 hours</b> <b>24 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of motorcycle which skidded and overturned.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>10:30am 4-29-67 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) <b>Cedarville Rd. 1 1/2 miles from Brandywine see</b>		20f. (City or town) (County) (State) <b>1 1/2 miles from Brandywine see</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Riverdale, Md.</b>			
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-6-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEMORY GARDENS</b>		23d. LOCATION (City or town) (County) (State) <b>CINCINNATI OHIO</b>	
24. FUNERAL DIRECTOR <b>W.H. Chambers Co</b>		ADDRESS <b>1400 Chapin St NW, Wash, D.C.</b>		25a. REC'D BY REGISTRAR <b>MAY 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05677

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05677

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert</b>		4. DATE OF DEATH Month <b>4</b> Day <b>2</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 Oct. 1896</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		10. USUAL OCCUPATION (Give kind of work done in most recent 12 months) <b>Ret. Sales Manager</b>	
11. BIRTHPLACE (State or foreign country) <b>Nabaska</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert P. Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Sallie A. Gale</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>281 12 9075</b>	
17. INFORMANT <b>Rose D. Murphy Same as #2 (wife)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>4-3-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Riverdale, Md.	
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>		23b. DATE THEREOF <b>4/6/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria National</b>		23d. LOCATION (City or Town) (County) (State) <b>Alexandria Va.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

M 05678

05678

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN lb <b>2 hrs. 40 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville,</b> d. STREET ADDRESS <b>5816 Maryhurst Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Esther Myers</b>		4. DATE OF DEATH Month Day Year <b>April 16, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-15-95</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Mo.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>secretary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Corrigan</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Cunningham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-50-1173</b>	
17. INFORMANT <b>JOHN H. MYERS</b>		2008 Address <b>JASMINE RD. BALTIMORE, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>acute Coronary occlusion</b> DUE TO (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>arterio sclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>12 mo</b> <b>8 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 16, 1967</b> to <b>April 16, 1967</b> , that (I) (we) lost saw the deceased alive on <b>April 16, 1967</b> and that death occurred at <b>7:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>L W Mahlin</b> M.D.		22b. DATE SIGNED <b>4/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L W MAHLIN, M.D.</b>		22d. ADDRESS <b>Riverdale, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-19-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM</b>	23d. LOCATION (City or Town) (County) (State) <b>BLADENBURG MD</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>		25a. REC'D BY REGISTRAR DATE <b>APR 20 1967</b>	
ADDRESS <b>Riverdale, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05679 CERTIFICATE OF DEATH 05679									
1. PLACE OF DEATH a. COUNTY <b>Prince George County</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b> 16-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>44 K Ridge Road</b>					d. STREET ADDRESS <b>44 K Ridge Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ETTA</b> Last <b>O'MALLEY</b>					4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3, 1903</b>		9. AGE (In years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Waitress</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James T. Sturgis</b>					14. MOTHER'S MAIDEN NAME <b>Oliver K. Griffin</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		15. INFORMANT <b>Joseph M. O'Malley</b>		Address <b>2624 Conn. Md. Ave. Columbia Pk.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> 443 X DUE TO (b) <b>Hypertensive &amp; arteriosclerotic heart disease with failure. Diabetes mellitus</b> DUE TO (c) <b>Obesity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Obesity</b>								INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1, 1965</b> to <b>April 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>4-19-1967</b> , and that death occurred at <b>12 M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>John R. Spencer</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>4-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN R. SPENCER, M.D.</b>					22d. ADDRESS <b>BURTONSVILLE, MD.</b>				
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Apr. 26, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., Riverdale, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



05673

05673

Prince George County, Maryland

Greenbelt

411 Ridge Road

MARYETTA O'NEAL

Nov. 2, 1962

Greenbelt, Md. 20861

James J. McGuire

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861

Greenbelt, Md. 20861



05681

## CERTIFICATE OF DEATH

05681

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDLE</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN lb <b>10 Hrs 32 Min</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LOTHIAN</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		d. STREET ADDRESS <b>PME, LOT 135A</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>KEITH</b> Last <b>PARKER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 APR 67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	9. AGE (In years last birthday) yrs. <b>10</b> Months <b>3</b> Days <b>10</b> Hours <b>32</b> Min.
11. BIRTHPLACE (County & State or foreign country) <b>ANDREWS AFB, COUNTY GEORGE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ABRAHAM (NMN) PARKER</b>		14. MOTHER'S MAIDEN NAME <b>PATTI ARLENE LA POINTE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NA</b>	17. INFORMANT <b>FATHER #, SAME AS # 2</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> 7730 DUE TO <b>HYALINE MEMBRANE DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 HRS</b> <b>10 HRS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3 APRIL</b> , 19 <b>67</b> , to <b>3 APRIL</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3 APRIL</b> , 19 <b>67</b> , and that death occurred at <b>0700PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Roger E. Spitzer, MD</i>		22b. DATE SIGNED <b>3 APRIL 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROGER E. SPITZER, CAPT, USAF, MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH D.C. 20331</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 6-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Steep Falls Cemetery, Inc.</b>	23d. LOCATION (City or Town) (County) (State) <b>Steep Falls, Maine</b>
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		25a. REC'D BY REGISTRAR <b>APR 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



18220



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05682  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES CO MD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANDOVER HILLS, MD</b> c. LENGTH OF STAY IN b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b> d. STREET ADDRESS <b>6814 - Decatur St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM P. PARRISH</b> First Middle Last		4. DATE OF DEATH <b>APRIL 14 1967</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCAS.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 3 1924</b> 9. AGE (In years last birthday) <b>43</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>	11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>
13. FATHER'S NAME <b>John W Parrish</b>		14. MOTHER'S MAIDEN NAME <b>May Prest</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>Birdie Parrish</b>		Address <b>Landover Hills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA, FIBRILLATION</b> DUE TO (b) <b>MYOCARDIAL ISCHEMIA</b> DUE TO (c) <b>ATHEROSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CHRONIC BRONCHITIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRONCHITIS</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>MORE THAN 5 YRS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>James W. Harding</b> attended the deceased from <b>JULY 1963</b> to <b>APRIL 14 1967</b> that (I) <b>yes</b> saw the deceased alive on <b>APRIL 14 1967</b> , and that death occurred at <b>1 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James W. Harding, M.D.</b>		22b. DATE SIGNED <b>April 14, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>James W. Harding, M.D.</b>		22d. ADDRESS <b>7601 RIVERDALE RD, NEW CARROLLTON MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 17, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town or county) <b>MD</b> (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05683

Item #11 infor. taken from birth cert.

# CERTIFICATE OF DEATH

05683

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 hrs. 51 mins</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>7216-79th Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy "A" Pasch</b>		4. DATE OF DEATH Month Day Year <b>April 12, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1967</b>
9. AGE (In years lost birthday) <b>n/a yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min. <b>5 51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cheverly, Pr. Geo. Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Bruce E. Pasch</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Ann Simone</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary Atelectasis Plat</b> <b>7625</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Prematurity 600 Gms</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>April 12, 1967</b> , to <b>April 12, 1967</b> , that <del>he</del> (we) lost the deceased alive on <b>April 12, 1967</b> , and that death occurred at <b>7:24 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Bernardo Alvarado, M. D.</b>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M. D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4/29/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hosp. Cheverly, PG Maryland</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Admin., Cheverly, Maryland</b>		25a. RECEIVED BY REGISTRAR <b>MAY 2 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



6387

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 42 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05684

Item #11 infor. taken from birth cert.

CERTIFICATE OF DEATH

05684

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 hr 17 mins</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville,</b> d. STREET ADDRESS <b>7216 - 79th Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Girl "B" Pasch</b>		4. DATE OF DEATH Month Day Year <b>April 12, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1967</b>
9. AGE (In years lost birthday) <b>n/a yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>1 17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cheverly, Pr. Geo. Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Bruce E. Pasch</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Ann Simone</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Steleckair Pul. Pontat</b> <b>7625</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pro Maturity 500 Grams</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>April 12, 1967</b> , to <b>April 12, 1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>April 12, 1967</b> , and that death occurred at <b>2:52 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Bernardo Alvarado, M. D.</b>		22b. DATE SIGNED <b>MAY 2 1967</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4/29/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hosp.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly PG Maryland</b>	
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Admin.</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



42220

53020

0022-0272/97 \$12.00 + .00

2000-01-01



FOR STATE  
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05686

05686

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>9222 Woodyard Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Marvin</b> Middle <b>William</b> Last <b>Peters</b>		4. DATE OF DEATH Month <b>4</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 August 1908</b>
9. AGE (In years last birthday) yrs. <b>58</b>		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>1</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Peters</b>		14. MOTHER'S MAIDEN NAME <b>Poland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year of dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>123-45-6789</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>8124</b> IMMEDIATE CAUSE (a) <b>Shock and hemorrhage</b> DUE TO <b>Bilateral hemothorax and multiple fractures -</b> (b) <b>(Right tibia and fibula,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Left tibia and fibula</b> (c) <b>Right Femur)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by car while crossing street</b>	
20c. TIME OF INJURY Month, Day, Year Hour, a.m. <b>4-8</b> 1967 p.m. <b>2:00</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Rt 5, at Alexandria Ferry Rd</b>		20f. (City or town) (County) (State) <b>P.G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D., Riverdale</b>		22. DATE SIGNED <b>4/8/67</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hotts Chapel</b>		23d. LOCATION (City or Town) (County) (State) <b>W. Va.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike</b>		25a. REC'D BY REGISTRAR <b>APR 11 1967</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



05282

05282

Prince George's

Barbados

Prince George's

Barbados

Barbados

3222 Woodward Rd.

Prince George's, Barbados

87

Barbados

Barbados

Barbados

28 August 1968

Barbados

Barbados

Barbados

Barbados

Shed and newspaper  
Altered newspaper and article  
(Right side and title)  
Left side and title  
Right side

Struck by car while crossing street

10. 4. 68

At Alexandria Ferry Rd

4-6 4-6

X X

Barbados, A.D. Barbados



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05687

CERTIFICATE OF DEATH

05687

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville (Adelphi)</b>		d. STREET ADDRESS <b>8406 Adelphi Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>S</b> Last <b>Peterson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Oct. 1901</b>
9. AGE (In years lost birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Kartlai</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Westerlund</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 46 2090T</b>	
17. INFORMANT <b>Norman E. Peterson, Sr. Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>157X Carcinoma of the head of the pancreas.</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1967</b> to <b>April 27, 1967</b> , that (I) (we) saw the deceased alive on <b>April 27, 1967</b> , and that death occurred at <b>1,30AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Aaron Deitz</b>		22b. DATE SIGNED <b>4/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M. D.</b>		22d. ADDRESS <b>Prince Georges Plaza, Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>	23d. LOCATION (City or Town) (County) (State) <b>Hyattsville P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



05587

05587

EXHIBIT OF DEATH

Prince Georges	Prince Georges
Hyattsville ( )	Chesley
38 days	
Prince Georges General Hospital	
White	
Hyattsville	
1901	
New Jersey	
Hyattsville	

*Continued on the back of the*

APR 28 1901

1-3008

APR 28 1901

1-3008



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05688

CERTIFICATE OF DEATH

05688

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Univeristy Park</b> d. STREET ADDRESS <b>6521 40th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pauline Mary Phelan</b>			4. DATE OF DEATH Month Day Year <b>April 20, 19 67</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>4-27-07</b>		9. AGE (In years last birthday) yrs. <b>59</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>2 0 0 0</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel L. Reynolds</b>	
14. MOTHER'S MAIDEN NAME <b>Mary M. Pendergast</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>daughter in law/medical record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE ACUTE</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-18-67, 1967</b> , to <b>4-20, 19 67</b> , that (I) (we) last saw the deceased alive on <b>4-20, 19 67</b> , and that death occurred at <b>10 A.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>C.J. Houmann</b>		22b. DATE SIGNED <b>4-20-67</b>		22c. PHYSICIAN'S NAME (Type) <b>C.J. Houmann, M. D.</b>	
22d. ADDRESS <b>4404 Queensbury Road, Riverdale, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>4/22/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Montg. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



02888

82028

UNITED STATES DEPARTMENT OF AGRICULTURE

Page 1

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UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**05689**

**CERTIFICATE OF DEATH**

**05689**

1. PLACE OF DEATH a. COUNTY <b>P. G.</b> <b>Riverdale,</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>P.G.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Md.</b>				c. LENGTH OF STAY IN lb <b>1 Day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Hospital</b>				e. STREET ADDRESS <b>4827 Lexington Ave.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Luella</b> Middle <b>M</b> Last <b>Pierce</b>				4. DATE OF DEATH Month <b>4-</b> Day <b>5</b> Year <b>19 67</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-96</b>		9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer USA</b>
13. FATHER'S NAME <b>Howard Springer,</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Hurst</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>87-01-8654</b>		17. INFORMANT Address <b>Eugene Leland Hospital, 4408 Queensbury Rd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Arterio-Sclerotic and Hypertensive Heart</b> (b) <b>Disease with Congestive Heart Failure</b> DUE TO <b>and Auricular Fibrillation</b> (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , to <b>4/5/67</b> , that (I) (we) last saw the deceased alive on <b>4/5/67</b> , and that death occurred at <b>12:30 P.M.</b> from causes on and on the date stated above.							
22a. SIGNATURE <i>Robert C. Wingfield</i>				22b. DATE SIGNED <b>4-6-1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert C. Wingfield, M.D.</b>	
22d. ADDRESS <b>329 Prince George Street</b>				22e. CITY OR TOWN <b>Laurel, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>April 8, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery,</b>		23d. LOCATION (City or town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Harold S. Wade, Laurel, Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05690

05690

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>		d. STREET ADDRESS <u>2807 63rd PL.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PETER (PIETRO) PIZZA</u>		4. DATE OF DEATH Month Day Year <u>April 1 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 JULY 1886</u>
9. AGE (In years last birthday) <u>80 yrs.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>
12. CITIZEN OF WHAT COUNTRY? <u>YES-USA</u>		13. FATHER'S NAME <u>Luigi Rizza</u>	
14. MOTHER'S MAIDEN NAME <u>Maria Tornelli</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>577-48-425A</u>		17. INFORMANT <u>KATHRYN SOIB-Pizza Ave Hyatts</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis, acute</u> DUE TO <u>Generalized Arteriosclerosis</u> (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
2De. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Hour a.m. p.m. <u>19</u>	2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2Df. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> , 19 <u>67</u> to <u>4/1</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>4/1</u> , 19 <u>67</u> , and that death occurred at <u>2:55</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman A. Comer</u> M.D.		22b. DATE SIGNED <u>4/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman A. Comer</u>		22d. ADDRESS <u>3503 Penny St Mt Rainier md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4 April 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Wash., D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>		25. REC'D BY REGISTRAR <u>APR 4 1967</u>	
ADDRESS <u>WASH. D.C.</u>		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



042310

[illegible]



**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**05691**

**CERTIFICATE OF DEATH**

**05691**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN lb <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>Box 6</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Estelle</u> Middle <u>G. Gibson</u> Last <u>Plotts</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>6</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/05</u>		9. AGE (In years (last birthday) yrs.) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert V. Gibson, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Iola Pearl Lane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>William S. Plotts-Box 6 Mitchellville, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April, 1962</u> to <u>4/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/6</u> , 19 <u>67</u> , and that death occurred at <u>10:15</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. Clark Holmes</u>				22d. ADDRESS <u>4108 Pratt St., Upper Marlboro, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Ritchie Bros. Upper Marlboro, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05001

05001

STATEMENT OF DEATH

Name of Deceased		Robert V. Gibson, Jr.	
Date of Death		April 10, 1968	
Place of Death		Chicago, Illinois	
Cause of Death		Heart Disease	
Age at Death		45 years	
Sex		Male	
Race		White	
Marital Status		Married	
Spouse's Name		Alice V. Gibson	
Occupation		Engineer	
Education		Bachelor's Degree	
Religion		Catholic	
Burial Place		Holy Cross Cemetery	
Burial Date		April 12, 1968	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Statement		April 15, 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05692

05692

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Memorial Hospital		d. STREET ADDRESS 10906 Dresden Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last Mabel Elizabeth Potter		4. DATE OF DEATH Month Day Year April 24 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 1 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Mason		14. MOTHER'S MAIDEN NAME Martha Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia E. Rolfes (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Interval between onset and death (Daughter) acute myocardial infarction 10 yrs arteriosclerotic heart 10 yrs General arteriosclerosis 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 4/24/67; that (I) (we) last saw the deceased alive on 4/24/67, and that death occurred at 7:44 M, from causes and on the date stated above.			
22a. SIGNATURE L W Malin		22b. DATE SIGNED 4-24-67	
22c. PHYSICIAN'S NAME (Type) L W MALIN M.D.		22d. ADDRESS Riverdale Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/27/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Com.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Home Inc.		25a. REC'D BY REGISTRAR MAY 1 1967	
Nalley's Funeral Home Inc.		25b. REGISTRAR'S SIGNATURE Charles Judge	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

Items 6-19-67 Film 389  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05693

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>5716 Chillum Heights Drive.</b>			
3. NAME OF DECEASED (Type or print) <b>Daniel Powell, Jr.</b>				4. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Sept. 1931</b>		9. AGE (In years lost birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months <b>18</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Powell Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Alice M. Stanton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Korean</b>		16. SOCIAL SECURITY NO. <b>579 38 2929</b>		17. INFORMANT <b>Mrs. Paula A. Jensen Same as #2 (sister)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents</b> DUE TO <b>922.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b>3</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D. Riverdale, Md.</b>				22. DATE SIGNED <b>4-19-67</b>			
23a. BURIAL, CREMATION, REMOVAL Specify <b>Burial</b>		23b. DATE THEREOF <b>4/21/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 file # 288 5/1/67 kk

05694

CERTIFICATE OF DEATH

05694

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>8601 Manchester Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice B. Prendable</b>			4. DATE OF DEATH Month Day Year <b>April 24, 1967</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1889-7-22</b>		9. AGE (In years last birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Andrew Huffman</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>579 18 3902</b>		17. INFORMANT <b>Frances Darwin Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolism, bilateral</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 465X					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>April 15, 1967</b> , to <b>April 24, 1967</b> , that (I) <del>we</del> last saw the deceased alive on <b>April 24, 1967</b> , and that death occurred at <b>2:45 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>B. Rosenberg</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 25, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Barry Rosenberg, M.D.</b>		22d. ADDRESS <b>6501 Landover Rd. Cheverly, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-27-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cem.</b>	
23d. LOCATION (City or Town) <b>Arlington, Virginia</b>		23e. REC'D BY REGISTRAR <b>MAY 1 1967</b>		23f. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		ADDRESS <b>Washington, D.C.</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05695

CERTIFICATE OF DEATH

05695

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>				d. STREET ADDRESS <b>4708 Sheridan St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jackson</b> Middle <b>L.</b> Last <b>Price</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-11-00</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Agent Insurance Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert H. Price</b>				14. MOTHER'S MAIDEN NAME <b>Emma E. Foster</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 10 0723</b>		17. INFORMANT <b>son/medical record</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of left leg</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 Min.</b> <b>5+ days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-5</b> , 19 <b>67</b> , to <b>4-20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-20</b> , 19 <b>67</b> , and that death occurred at <b>11:45 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>C. J. Houmann</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-20-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. J. HOUMANN</b>				22d. ADDRESS <b>RIVERDALE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/22/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P. G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05696 CERTIFICATE OF DEATH 05696

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Juliette Drive		d. STREET ADDRESS Juliette Drive	
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last PRYDE		4. DATE OF DEATH Month April Day 12th Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31-1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Principle-Surrattsville Senior High		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Pryde		14. MOTHER'S MAIDEN NAME Agnes Mc Multy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Elizabeth A. Pryde (Wife)		Address Same # 2 as	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden Cardiac Vessel Rupture (c) DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 Day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 4-16, 1967, to 4-12, 1967 that (1) (we) last saw the deceased alive on 4-10, 1967, and that death occurred at 6:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE Richard H. Dobson		22b. DATE SIGNED April 12-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Richard H. Dobson		22d. ADDRESS Brandywine, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 15-67	
23c. NAME OF CEMETERY OR CREMATORY Plum Creek Cemetery		23d. LOCATION (City, town or county) (State) New Kensington, Pa.	
24. FUNERAL DIRECTOR ADDRESS Simmons Bros. 1661- Gd. Hope Road Se. Wash., DC		25a. REC'D BY REGISTRAR APR 14 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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APR 1 1951

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FBI  
APR 1 1951

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

APR 1 1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05697 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						05697 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale						c. LENGTH OF STAY IN 1b 2 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital						d. STREET ADDRESS 5731 29th Avenue					
3. NAME OF DECEASED (Type or print) First Marie Middle Purcell Last Purcell						4. DATE OF DEATH Month 4 Day 15 Year 1967					
5. SEX Fem.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-82		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) England				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -- Potts						14. MOTHER'S MAIDEN NAME --					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 215-50-0126		17. INFORMANT Hospital Admission Record					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL AORTIC ANEURYSM 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 4-13, 1967, to 4-15, 1967, that (I) (we) last saw the deceased alive on 4-14, 1967, and that death occurred at 4:50 A.M. from the causes and on the date stated above.											
22a. SIGNATURE C.J. Houmann						22b. DATE SIGNED 4-15-67					
22c. PHYSICIAN'S NAME (Type) C.J. HOUMANN						22d. ADDRESS RIVERDALE MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City, town or county) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons						25a. REC'D BY REGISTRAR APR 18 1967					
ADDRESS Hyattsville, Md.						25b. REGISTRAR'S SIGNATURE Charles Judge					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>D O A</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOWIE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					d. STREET ADDRESS <b>3500 MOYLAN DRIVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>BOUCK</b> Last <b>REED</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1967</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>10/3/1892</b>		9. AGE (In years lost birthday) <b>74</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>SOUTH DAKOTA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>CYRUS BOUCK</b>					14. MOTHER'S MAIDEN NAME <b>IDA HOYT</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>PAULINE SCHEUFLE</b> Address <b>SAME AS # 2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AUG</b> , 1966, to <b>APRIL</b> , 1967, that (I) <del>was</del> lost saw the deceased alive on <b>APRIL 5</b> 1967, and that death occurred at <b>10 30 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Norman K Bohrer</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>April 6, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Norman K. Bohrer</b>					22d. ADDRESS <b>3231 Superior Lane, Bowie, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUND HILL CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>PARISHVILLE, NEW YORK</b>		
24. FUNERAL DIRECTOR <b>ROBERT E. WILHELM FUNERAL HOME</b> <b>4308 SUTLAND ROAD, SUTLAND, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>APR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



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Prince George's

Marshall

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Cherry

B.A.

Bowie

Prince George's General Hospital

1200 Mylan Drive

Florence

Red

in Area

Prince

MYOCARDIAL INFARCTION

DIABETES MELLITUS

Wm. K. Brown

April 2, 67

Dr. Norman K. Brown

8181 Superior Ave., Bowie, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05693

Item #7 Film #G388 4/26/67 pg

CERTIFICATE OF DEATH

05699

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		d. STREET ADDRESS <b>6901 Riverdale Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MATILDA</b> Middle <b>B.</b> Last <b>RENALDS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1884</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 Year Months <b>1</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Warren Co, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Casper L. Craig</b>		14. MOTHER'S MAIDEN NAME <b>Linda Triplett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220 54 1249</b>	
17. INFORMANT <b>Lauretta G. Rusk Same as #2 (daughter)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/26</b> , 19 <b>67</b> , to <b>4/1</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/1</b> , 19 <b>67</b> , and that death occurred at <b>6:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Frederick H. Wilhelm</b>		22b. DATE SIGNED <b>4/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frederick H. Wilhelm, M.D.</b>		22d. ADDRESS <b>6314 Landover Road; Cheverly, Md.</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/4/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Front Royal Va.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05700

CERTIFICATE OF DEATH

05700

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel - Rural</b> d. STREET ADDRESS <b>Box 210-B - Route #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Howard G. Rice</b>			4. DATE OF DEATH Month Day Year <b>April 18 19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1891</b>	9. AGE (In years last birthday) <b>76</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Howard Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Godfrey Rice</b>			
14. MOTHER'S MAIDEN NAME <b>Augusta Kalkack</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Howard Rice Jr. Laurel Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Acute Coronary Thrombosis</b> DUE TO (c) <b>Severe Cardiovascular Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (the hospital) attended the deceased from <b>March 31, 1967</b> , to <b>April 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 18, 1967</b> , and that death occurred at <b>12:15</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Klon B. Cameron</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. AM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 18, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Don B. Cameron, M.D.</b>		22d. ADDRESS <b>3503 Perry St., Mt. Rainier, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-21-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>	23d. LOCATION (City or Town)	(County)	(State) <b>Pheffer Corners Md.</b>
24. FUNERAL DIRECTOR <b>De Witt Donaldson</b>		ADDRESS <b>Laurel Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
DATE <b>APR 27 1967</b>					



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APR 21 1967



05701

## CERTIFICATE OF DEATH

05701

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>1 &amp; 1/2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>215 Rt. #3, Box <del>XXXX</del></b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dora Estelle Richards</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/3/02</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>James T. Canter</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>-----</b>				17. INFORMANT <b>Benjamin E. Richards</b> Address <b>Rt 3, Box 204-B Brandywine, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Vascular disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>April 23, 1967</b> to <b>April 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 25, 1967</b> , and that death occurred at <b>11:25M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Frederick H. Wilhelm</b>				22b. DATE SIGNED <b>4/25/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Frederick H. Wilhelm, M.D.</b>	
22d. ADDRESS <b>6319 Landover Rd., Cheverly, Maryland</b>				22e. REC'D BY REGISTRAR DATE <b>MAY 5 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brookfield Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Naylor Md.</b>	
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>				25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of other death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05702

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05702

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert A Rogers</b>		4. DATE OF DEATH Month <b>4</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 May 1912</b>
9. AGE (In years lost birthday) yrs. <b>54</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Rogers</b>		14. MOTHER'S MAIDEN NAME <b>Irene Bowler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Joseph Rogers Jr. Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>Fracture of skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>4-20- 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>same as #2</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-24-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/26/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Grace Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rollins Fork Va.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25. REGISTRAR'S SIGNATURE <b>APR 26 1967</b>	



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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05703

CERTIFICATE OF DEATH

05703

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 2909 Fairlawn St.	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret E. Rollins		4. DATE OF DEATH Month Day Year April 2, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1914
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee School Board P. Geo. Co.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George F. Simpson		14. MOTHER'S MAIDEN NAME Margaret E. McWilliamson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no		16. SOCIAL SECURITY NO.	
17. INFORMANT Wallace L. Rollins 2909 Fairlawn St.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750 Edema complicating stroke DUE TO (b) with metastasis DUE TO (c) months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 26-28, 19 67 to April 2, 19 67, that (I) (we) last saw the deceased alive on 26-28, 19 67, and that death occurred at 3:57 P.M. from causes and on the date stated above.			
22a. SIGNATURE T. O'Donovan		22b. DATE SIGNED April 2, 19 67	
22c. PHYSICIAN'S NAME (Type) T. O'DONOVAN		22d. ADDRESS 4000 Stan PRd SE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-4-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Suitland P. G. Md.
24. FUNERAL DIRECTOR Robert E. Wilhelm Fun Home		25a. REC'D BY REGISTRAR APR 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Suitland, Md.	



80720

WIND TO 100 MPH

80720



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

Approval to sign certificate by Dr. Walters, coroner - J. Walters

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3450 Toledo Terrace		d. STREET ADDRESS 3450 Toledo Terrace	
3. NAME OF DECEASED (Type or print) JAMES ARTHUR ROSENBERGER		4. DATE OF DEATH APRIL 6 1967	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1874
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		9b. KIND OF BUSINESS OR INDUSTRY Railroad	
10a. BIRTHPLACE (County & State, or foreign country) Sandusky County Ohio		10b. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. FATHER'S NAME Perry F. Rosenburger		12. MOTHER'S MAIDEN NAME Clarissa Hummel	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. SOCIAL SECURITY NO. 051 070158	
15. INFORMANT Mrs. Rella M. Rosenburger (same as #2)		16. ADDRESS	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular d. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min. years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan. 1965, to Apr. 1967, that (2) (we) last saw the deceased alive on Dec 2 1966, and that death occurred at 7:30 AM, from the causes and on the date stated above.		22a. SIGNATURE James R. Coleman MD	
22b. DATE SIGNED Apr 6, 1967		22c. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN	
22d. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING MD.		22e. REC'D BY REGISTRAR	
22f. DATE APR 10 1967		22g. REGISTRAR'S SIGNATURE J. Walters	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 10, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) Pr. Geo. Co. Maryland	
23e. FUNERAL DIRECTOR J. Walters, 254 Carroll St. NW. DC		23f. ADDRESS	



08704

08704

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]*



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05705

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9533 Riggs Road</b>		d. STREET ADDRESS <b>9533 Riggs Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Ross</b>		4. DATE OF DEATH Month Day Year <b>4 25 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Feb. 1883</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>? Ross</b>		14. MOTHER'S MAIDEN NAME <b>-----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Patrick Ross Same as #2 (son)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive bilateral anthra silicosis</b> <b>5231</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>And bilateral bronchopneumonia</b> DUE TO (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>4-26-67</b>	
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/28/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattsville P. G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. ACC'D BY REGISTRAR DATE <b>APR 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



05702

05702

(200)

and official correspondence

George V. ...

05702

05702



## CERTIFICATE OF DEATH

05706

05706

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON, MARYLAND</u>				c. LENGTH OF STAY IN 1b <u>11-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland General Hospital</u>				d. STREET ADDRESS <u>11419 Edmonston Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>LEE</u> Middle <u>A</u> Last <u>ROSS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Beltsville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry Ross</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Agnes Ross</u> Address <u>Same as 2D</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4213 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIO PULMONARY INSUFFICIENCY</u> DUE TO (c) <u>SCLERODERMA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>4 MONTHS</u> <u>3 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MYOCARDIAL INFARCTION</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A.</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>N/A.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/28/1967</u> , to <u>4/25/1967</u> , that (I) <del>saw</del> saw the deceased alive on <u>4/25/1967</u> , and that death occurred at <u>11:15 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u>				22d. ADDRESS <u>50. MARYLAND GEN. HOSP. CLINTON, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-29-67</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Queen's Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>Manassas Md</u>	
24. FUNERAL DIRECTOR <u>AS Washington &amp; Sons 4925 Deane Ave NE</u>				25a. REC'D BY REGISTRAR DATE <u>APR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05708

05708

Clinton, Maryland  
 Southern Maryland General Hospital  
 Baltimore, Maryland  
 Prince Georges  
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1-2-57  
 General Hospital  
 Prince Georges  
 Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05707						05707					
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE</u>				c. LENGTH OF STAY IN 1b <u>5 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12503 SCARLET LANE</u>						d. STREET ADDRESS <u>12503 SCARLET LANE</u>					
3. NAME OF DECEASED (Type or print) <u>LEONE</u> <u>N</u> <u>ROSS</u>						4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1967</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 17, 1915</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NAT. RIFLE ASSOC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DALLAS CT, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>			
13. FATHER'S NAME <u>WILLIAM NOBENS</u>						14. MOTHER'S MAIDEN NAME <u>ANNA MAE FISH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>474-14-5857</u>		17. INFORMANT Address <u>HUSBAND - HARRY ROSS</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANEMIA</u> <u>2013</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>ACUTE MYELOGENOUS LEUKEMIA</u> (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>APRIL</u> , 19 <u>67</u> , to <u>APRIL</u> , 19 <u>67</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>APRIL 9</u> , 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Norman K. Bohrer</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 9, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Norman K Bohrer</u>						22d. ADDRESS <u>3231 SUPERIOR LANE BOWIE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town or county) <u>Colmar Manor Pro Geo</u>		(State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>						ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Gage</u>	



05505

50750



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05708

05708

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> 16.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>3922 Suitland Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Glenn Isadore Rothenberg</b>				4. DATE OF DEATH Month Day Year <b>4 5 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 April 1945</b>		9. AGE (In years lost birthday) <b>21</b> yrs.	10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SAILOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		11. BIRTHPLACE (State or foreign country) <b>Ogden, UTAH</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LIONEL ROTHENBERG</b>				14. MOTHER'S MAIDEN NAME <b>Stella ROMERO</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes ACTIVE Duty</b>		16. SOCIAL SECURITY NO. <b>520-44-7973</b>		17. INFORMANT <b>Sheila H. ROTHENBERG, 3922 Suitland Rd, Suitland, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Traumatic rupture of aorta and right atrium</b> DUE TO <b>And laceration of right lung</b> (b) <b>From trauma auto accident</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car which ran off road and hit cement pillar.</b>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>2:10am 4-5- 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Prince George Co., Md.</b>		20f. City or town (County) (State) <b>Suitland Rd, 2000 ft. west of Arnold Rd.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>4-6-67</b>		22. DATE SIGNED <b>4-6-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>Ft. Meyer Va</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Corp. 517 11th St SE Wash. DC</b>				25a. REC'D BY REGISTRAR <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Michaela Judge</b>	

W.W. Chambers Corp. 517 11th St SE, Wash. DC

APR 10 1967

Michaela Judge



80726



THE PRINCE GEORGE COUNTY MEDICAL EXAMINER WAS NOTIFIED AND HE  
RELEASED THE REMAINS TO THIS HOSPITAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05709

CERTIFICATE OF DEATH

05713

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLCREST HGTS 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 2304 DAWSON ST.	
3. NAME OF DECEASED (Type or print) JOSEPH MILTON STONGE		4. DATE OF DEATH APRIL 4 19 67	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 APRIL 1913
9. AGE (In years last birthday) yrs. 53		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED NAVAL OFFICER US NAVY		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MERIDEN, CONN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH E. ST ONGE		14. MOTHER'S MAIDEN NAME SARAH JANE WALSH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1931-1961		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS MARY E. STONGE SAME AS # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 452X artery with rupture and hemorrhage. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from 7 MARCH, 1967, to 4 APRIL, 1967, that (A) (we) last saw the deceased alive on 29 MARCH 1967, and that death occurred at 820P M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 5 APRIL 1967	
22c. PHYSICIAN'S NAME (Type) ARTHUR A. ALTMAN, MAJ, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH, D.C. 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 7-1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		23d. LOCATION (City or Town) Arlington, Virginia	
24. FUNERAL DIRECTOR Simmons Bros		25a. REC'D BY REGISTRAR APR 7 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05710

05709

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY CONNECTICUT NEW LONDON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE		c. LENGTH OF STAY IN lb 7 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GROTON MUNFORD COVE		d. STREET ADDRESS 5 NEPTUNE DRIVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE MESSER SAMPSON		4. DATE OF DEATH APRIL 11 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 MAR 04
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State, or foreign country) CONCORD, MASS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADELBERT MESSER		14. MOTHER'S MAIDEN NAME CLARA CHAPLAIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. 045-38-4688	
17. INFORMANT HUSBAND		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory &amp; Cardiovascular failure</u> DUE TO (b) <u>Septic Shock</u> DUE TO (c) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 days 11 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia, Chronic Renal Disease, Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4 April</u> , 19 <u>67</u> , to <u>11 April</u> , 19 <u>67</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>11 April</u> , 19 <u>67</u> , and that death occurred at <u>12:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John Bristow MD</u>		22b. DATE SIGNED 11 April 67	
22c. PHYSICIAN'S NAME (Type) JOHN W. BRISTOW, CAPT USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/13/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR ROBERT E. WILHELM 4308 SUTLAND ROAD, SUTLAND, MARYLAND		25a. RECEIVED BY REGISTRAR APR 17 1967 DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



05709

CERTIFICATE OF DEATH

05710

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

AGE AT DEATH  
SEX  
RACE  
BIRTH DATE  
BIRTH PLACE  
MARRIAGE DATE  
MARRIAGE PLACE

EDUCATION  
OCCUPATION  
RELIGION  
MILITARY SERVICE  
CIVIL SERVICE  
SOCIAL SECURITY NUMBER

PREVIOUS ILLNESS  
PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL  
PREVIOUS TOBACCO

PREVIOUS INJURY  
PREVIOUS FALLS  
PREVIOUS VEHICLES  
PREVIOUS WEAPONS  
PREVIOUS FIRES  
PREVIOUS OTHER



05715

## CERTIFICATE OF DEATH

05714

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>Princess Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Essex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maplewood</u>	
c. LENGTH OF STAY IN 1b <u>3-26-67</u> <u>4-17-67</u>		d. STREET ADDRESS <u>70 Essex Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paint Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence D</u> Middle <u>Serom</u> Last <u>Serom</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-1895</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Engineer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Clarence Serom</u>		14. MOTHER'S MAIDEN NAME <u>Addie Sawyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>145-03-3561</u>	
17. INFORMANT <u>M. Wallace Son</u>		Address <u>11451 Cherry Hill Beltsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Constrictive heart failure</u> DUE TO <u>  </u> (c) <u>Myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u> <u>5 yrs.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hemiplegia from previous C.V.A.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>67</u> , to <u>4-17</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>4-12</u> , 19 <u>67</u> , and that death occurred at <u>11:55 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>R.D. Baner, MD.</u>		22b. DATE SIGNED <u>4-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.D. Baner, MD.</u>		22d. ADDRESS <u>2513 Bucklonge Rd. Adelphi, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fair View Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Amsterdam, New York</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>APR 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02711

NEW STATE OF TEXAS

02711

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05711

CERTIFICATE OF DEATH

05710

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>5 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>Box 297</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy (A) Seal</b>		4. DATE OF DEATH Month Day Year <b>April 3 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1967</b>
9. AGE (In years last birthday) yrs. <b>5</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Larry Seal</b>		14. MOTHER'S MAIDEN NAME <b>Sandra Lee Shaw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Larry Seal</b>		Address <b>Same as 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature</b> 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>April 3, 1967</b> , to <b>April 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>7:40 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Andrew G. Aronfy</b>		22b. DATE SIGNED <b>April 4, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew G. Aronfy, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-4-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Seals Farm</b>	23d. LOCATION (City or Town) (County) (State) <b>Ethison, Mont. Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Francis H. Barber</b>	



05710

EXHIBIT OF DEATH

05710

Prisoners

Prisoners

Prisoners

Jeep

5 hours

Cherry

Box 207

Prince Georges General Hospital

Seal

Box (1)

Box

April 1, 1967

White

Male

Seal in Box

Seal

*Signature*

April 3, 67

XX

April 3, 67

April 3, 67

April 4, 1967

Prince Georges General Hospital

Andrew G. Armitage, M.D.

Richmond, Mont. Md.

Seal in

11-1-67

Barrel

Francis H. Beyer, Jaynesville, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
05712		CERTIFICATE OF DEATH	
05711			
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 hrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup</b>		d. STREET ADDRESS <b>Box 297</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy ( B )</b> Last <b>Seal</b>		4. DATE OF DEATH Month <b>3</b> Day <b>April</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 April 1967</b>
9. AGE (In years last birthday) Yrs. <b>3</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Larry Seal</b>		14. MOTHER'S MAIDEN NAME <b>Sandra Lee Shaw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Larry Seal</b>		Address <b>Same as 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>176X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 3, 1967</b> , to <b>April 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>5:20 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Andrew G. Aronfy</b>		22b. DATE SIGNED <b>4/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew G. Aronfy, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-4-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Seals Farm</b>		23d. LOCATION (City or Town) (County) (State) <b>Etchison Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

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Overland of Chicago

— — — — — 12/1/2019

1997-1998

Ernest H. Harper, Paysonville, Mo.

DATE \_\_\_\_\_ TIME \_\_\_\_\_



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05713

05717

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	
3. NAME OF DECEASED (Type or print) <b>MAUREEN Frances SHUMAKER Shoemaker</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) yrs. <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sally</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRAVEL CONSULTANTS, INC.</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRANCIS X. SHUMAKER</b>		14. MOTHER'S MAIDEN NAME <b>MARION RODDY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. MARION SHUMAKER</b> Address <b>SAME AS #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> 8194 DUE TO (b) <b>Trauma-Auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Driver of car involved in collision.</b> 20c. TIME OF INJURY Month, Day, Year Hour, a.m. <b>3:15AM</b> 4-1-67 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 495 east of Balto-Wash Pkwy, P.G. Md.</b> 20f. (City or town) (County) (State) <b>Riverdale, Md.</b> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> 22. DATE SIGNED <b>4-1-67</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>APRIL 4, 1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b> 23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D.C.</b> 24. FUNERAL DIRECTOR <b>W.W. CHAMBERS GO. RIVERDALE, MD</b> 25a. REC'D BY REGISTRAR <b>APR 4 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



1. *Journal of the American Medical Association*, 1997; 278: 1023-1028.

• 1994 • 023461-21



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

05714

05712

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10120 Dubarry Street</b>		d. STREET ADDRESS <b>10004 Dubarry Street</b>	
3. NAME OF DECEASED (Type or print) <b>Frederick William Sinyard</b>		4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1909</b>
9. AGE (In years last birthday) yrs. <b>57</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Sinyard</b>		14. MOTHER'S MAIDEN NAME <b>Margaret V. Fraley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 07 3017</b>	
17. INFORMANT <b>Catherine M. Sinyard Same as #2 (wife)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery occlusion with Infarction</b> 4201 DUE TO (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) <b>3 previous coronary attacks</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 previous coronary attacks</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>65</b> , to <b>4/23</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/21</b> , 19 <b>67</b> , and that death occurred at <b>4:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>H. James Kurtz</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>		22d. ADDRESS <b>RFD Glenn Dale Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/26/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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Frederick William Zirkel

4 23 19

Attorney General  
Department of Justice  
Washington, D.C.

3 Bureau covered a check

H. James  
Kurtz  
4/5/61

Feb

4/5

4/3 19

REC. James D. J. 4/3



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

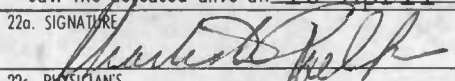
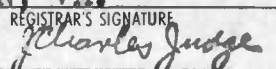
VR A15 (4)  
20 M 1/66

05716

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05715

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF Hospital Andrews</b>		d. STREET ADDRESS <b>1619 SUTERS LN N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>RUTH T SENTER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	9. AGE (In years last birthday) yrs. <b>51</b>
11. BIRTHPLACE (County & State, or foreign country) <b>TENNESSEE</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILLIP J. TINSLEY</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN CUNYUS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>-LT.GEN'L. W.O. SENTER, SEE ITEM #9</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Metastatic Carcinoma of Breast</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>6 April, 1967</b> , to <b>18 April, 1967</b> , that <del>(x)</del> (we) last saw the deceased alive on <b>18 April 1967</b> , and that death occurred at <b>4:10M</b> , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>18 Apr 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES D. PHELPS, CAPT USAF MC</b>		22d. ADDRESS <b>USAF Hospital Andrews Andrews AFB Wash DC 20331</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-21-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VA.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>APR 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE 	



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CONTINUATION OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH



## CERTIFICATE OF DEATH

05717

05716

1. PLACE OF DEATH COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>8-D Greenbelt, Md.</b> <del>MD</del> <b>Hillside Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Shiren - Alvin</b>		4. DATE OF DEATH Month Day Year <b>April 12, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/13</b> <del>MD</del>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ART DIRECTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US. AIR FORCE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BRONX, NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LAZARUS SHIREN</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIA ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>075-12-1999</b>	
17. INFORMANT <b>SCHWARTZ BROS. FOREST HILLS, LONG ISLAND</b>		Address <b>N.Y.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Pulmonary Embolism</b> DUE TO (b) <b>Myocardial infarction</b> DUE TO (c) <b>arteriosclerosis heart and</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 1967, to <b>April 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 12, 1967</b> , and that death occurred at <b>1:45 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>William C. Weintraub, M.D.</b>		22b. DATE SIGNED <b>April 12, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>William C. Weintraub, M.D.</b>		22d. ADDRESS <b>Professional Bldg. Greenbelt, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/13/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. HEBRON</b>		23d. LOCATION (City or Town) (County) (State) <b>FLUSHING, NEW YORK</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>5216 U St. S.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>C</b> Last <b>Sims</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 April 1897</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>4</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railroad Express</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Alabama</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jeptha P. Sims</b>		14. MOTHER'S MAIDEN NAME <b>Janie Mc Colleston</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lela J. Sims (Wife)</b>		Address <b>Same as # 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>177X Generalized Carcinomatosis</b> IMMEDIATE CAUSE (a) <b>Carcinoma of prostate</b> DUE TO (b) <b>2 yrs.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 6, 1967</b> , to <b>April 12, 1967</b> , that (I) (we) saw the deceased alive on <b>April 12, 1967</b> , and that death occurred at <b>4:40 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Julius Kauffman</b> M.D.		22b. DATE SIGNED <b>4/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Julius Kauffman, M.D.</b>		22d. ADDRESS <b>6501 Landover Rd. Cheverly, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 15-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	
ADDRESS <b>1661- Gd. Hope Rd. SE. Wash., DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



05718

STATE OF NEW YORK

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Office of the

Attorney General

Office of the

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05719

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frances Gravely Slason</b>				4. DATE OF DEATH Month <b>4</b> Day <b>20</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-23-1923</b>	
9. AGE (In years last birthday) yrs. <b>43</b>		10a. USUAL OCCUPATION (Give kind of work done during last week, or if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13. FATHER'S NAME <b>Clay Webster Gravely</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Lou Harbin</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Frank Kane Slason same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> DUE TO <b>Cirrhosis of the liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED <b>4-21-67</b>				23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
24. ACTUAL SIGNATURE <b>John Kenoe, M.D.</b> EXAMINER'S NAME (Type) <b>John Kenoe, M.D. Riverdale, Md.</b>				25. ADDRESS <b>The S.H. Hines Company</b> <b>2901 14th St. N.W. Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b> <b>2901 14th St. N.W. Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

APR 24 1967



05712

Prince George's

University

1901

1912-1913

Prince George's

1914

1915

1916

1917-1918

1919

1920

1921

University of the River

John K. K. K.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #7 File #G388 1/25/67 pc

05720

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05720

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DCA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>79 Nottingham Terrace</b>	
3. NAME OF DECEASED (Type or print) <b>Clayton M. Smith</b>		4. DATE OF DEATH Month <b>4</b> Day <b>17</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Aug., 1884</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
12a. BIRTHPLACE (State or foreign country) <b>New York</b>		12b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anselm J. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Catherine M. Morgan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>over 3 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale</b>		22. DATE SIGNED <b>4-17-67</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Com.</b>		23d. LOCATION (City or Town) (County) (State) <b>Buffalo, N.Y.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 19 1967</b>	
ADDRESS <b>Mt. Rainier Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



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08730

New York

John F. Kennedy

1964

John F. Kennedy

John F. Kennedy

John F. Kennedy

John F. Kennedy

John F. Kennedy

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John F. Kennedy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05721

CERTIFICATE OF DEATH

05721

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 5902-31st Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary None Speropulos				4. DATE OF DEATH Month Day Year 4 22 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-96	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Kakavos				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Medical records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Metastatic carcinoma DUE TO (c) Carcinoma right breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 30 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/18, 1966, to 4/22, 1967, that (I) (we) last saw the deceased alive on 4/22, 1967, and that death occurred at 9 P. M., from causes and on the date stated above.							
22a. SIGNATURE Earl W. Graeff				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/23/67.	
22c. PHYSICIAN'S NAME (Type) EARL W. GRAEFF, M.D.				22d. ADDRESS 2716 Kirkwood Pl. W. Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Jas. T. Ryan, Inc.				ADDRESS 317 Pa. Ave., SE DC		25a. REC'D BY REGISTRAR APR 26 1967	
						25b. REGISTRAR'S SIGNATURE Charles Judge	



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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05722

05722

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home		d. STREET ADDRESS 310 Onondaga Drive	
3. NAME OF DECEASED (Type or print) First Middle Last May B Stewart		4. DATE OF DEATH Month Day Year 4 20 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1893
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Hausch		14. MOTHER'S MAIDEN NAME Anna Mary Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Bell Shenherd		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Cervix 171X Conditions, if any, which gave rise to immediate cause (b). stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-3, 1967, to 4-20, 1967, that (I) (we) last saw the deceased alive on 4-19, 1967, and that death occurred at 8:30 A.M. from causes on and on the date stated above.			
22a. SIGNATURE WB Sheer		22b. DATE SIGNED 4-20-67	
22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22d. ADDRESS 6400 MARLBORO PKE S.E. WASH. D.C. 20028	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/22/67	23c. NAME OF CEMETERY OR CREMATORY Boston Hghts. Cem.	23d. LOCATION (City or Town) (County) (State) Summit County Ohio
24. FUNERAL DIRECTOR J. Wm. Lees Sons, Washington, D. C.		25a. REC'D BY REGISTRAR DATE APR 21 1967	25b. REGISTRAR'S SIGNATURE Michaela Under



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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05723					05723						
1. PLACE OF DEATH a. COUNTY <b>Prince Geo.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN 1b <b>7 mos. 18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Manor Home for the Aged</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> d. STREET ADDRESS <b>5023 - Riverdale Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>K.</b> Last <b>Stickney</b>			4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1967</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/15/1876</b>		9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Kenney</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-62-3516</b>		17. INFORMANT Address <b>Mr. Geo. F. Stickney (above add- (Son) (ress)</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic myocarditis &amp; failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-vascular renal degenerative</b> DUE TO (c) <b>12 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>3-4 weeks</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 1966, to <b>April 2</b> , 1967, that (I) (we) last saw the deceased alive on <b>April 2</b> , 1967, and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Frank R. Shea</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>4/3/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>FRANK R. SHEA</b>					22d. ADDRESS <b>4100-22nd St NE Wash DC 20018</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/8/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Rose of Lima Com.</b>			23d. LOCATION (City, town or county) (State) <b>Littleton, N.H.</b>			
24. FUNERAL DIRECTOR <b>Home Inc.</b>					25a. ADDRESS <b>Nalley's Funeral Home Inc. Maryland</b>			25b. REC'D BY REGISTRAR <b>APR 7 1967</b>		25c. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



6520



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

05724

05724

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>6909 Adel St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gladys B. Taylor</b>		4. DATE OF DEATH Month Day Year <b>April 5, 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/11/01</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>6 months</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt P.O.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Austin, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Bonte</b>		14. MOTHER'S MAIDEN NAME <b>Tutt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>449-01-6257</b>	
17. INFORMANT <b>Bradford L. Taylor</b>		18. Address <b>Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the in testines</b> DUE TO (b) <b>Metastases, w/ no spread in abdomen</b> DUE TO (c) <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>March 27, 19 67</b> , to <b>April 5, 19 67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>April 5, 19 67</b> , and that death occurred at <b>8:55 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Peter Duus</b>		22b. DATE SIGNED <b>April 5, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter Duus, M.D.</b>		22d. ADDRESS <b>6124 Central Ave. Capitol Hghts. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-8-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince George Co Maryland</b>
24. FUNERAL DIRECTOR <b>Metzger 131-11th St. S.E. D.C.</b>		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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05724

Prince George

Prince George

Prince George

East Richmond

East Richmond

East Richmond

East Richmond

April

April

April

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Female

*Handwritten signature*

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APR 2 1967

APR 2 1967

*Handwritten signature*

State Central Ave. Capitol Building, W.D.

State Central Ave. Capitol Building, W.D.



CERTIFICATE OF DEATH

05725

05725

1. PLACE OF DEATH e. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Magnolia Gardens Nursing Home</b>		d. STREET ADDRESS <b>RFD Box 4010</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Arthur Raleigh Tayman</b>		4. DATE OF DEATH Month Day Year <b>April 18, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1887</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Richard Henry Tayman</b>	
14. MOTHER'S MAIDEN NAME <b>Eleanor-----</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>213-42-6805</b>		17. INFORMANT Address <b>RR Box 4799 Upper Marlboro, Md.</b> <b>Mrs. Virginia K. Phillips</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal failure</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cardiovascular disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>August 2, 1967</b> to <b>April 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 18, 1967</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Clark Holmes, M. D.</b>		22b. DATE <b>4/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M. D.</b>		22d. ADDRESS <b>Upper Marlboro, Maryland 20870</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>		25. REC'D BY REGISTRAR <b>MAY 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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Prince Georges

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Nov. 2, 1987

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Richard Henry Tenore

PR Box 1002

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Box 1002



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05726

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> d. STREET ADDRESS <b>8114 Redwood Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Claude Zaddock Tayman</b>		4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>1967</b>								
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1906</b> <del>March 1, 1905</del>	9. AGE (In years last birthday) <b>61</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Employed District Foreman</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Claude W. Tayman</b>		14. MOTHER'S MAIDEN NAME <b>May Smith</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>				16. SOCIAL SECURITY NO. <b>214-28-7634</b>	17. INFORMANT <b>Ruth A. Tayman</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO (b) <b>Occlusion of anterior descending artery by thrombus and hemorrhage into plaque.</b> DUE TO (c) <b>thrombus and hemorrhage into plaque.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>4-7-67</b>		23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/9/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Croom Md.</b>
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		25. REC'D BY REGISTRAR <b>APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



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Rockville

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City of

Bill Bedford

Police Department

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05727

## CERTIFICATE OF DEATH

05727

1. PLACE OF DEATH a. COUNTY <i>Prince Georges County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>D. O. A.</i>		15.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Leland Memorial Hospital</i>		d. STREET ADDRESS <i>11610 Gail Place</i>	
3. NAME OF DECEASED (Type or print) <i>Sylvester</i>		4. DATE OF DEATH <i>April 22, 1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 2, 1887</i>
9. AGE (In years lost birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR Months <i>15</i> Days <i>2</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Hinton Jew</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>YES</i>	
17. INFORMANT <i>Clarence Jew</i>		Address <i>4508 Landgreen Street Rockville, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4201</i> IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>1 year</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10/31</i> , 19 <i>66</i> , to <i>4/22</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/20</i> , 19 <i>67</i> , and that death occurred at <i>10:40</i> P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>D. P. Washington</i>		22b. DATE SIGNED <i>4/24/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>D. P. Washington M.D.</i>		22d. ADDRESS <i>5702 Ridgefield Rd. Bethesda Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Apr 25, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>
24. FUNERAL DIRECTOR <i>John B. Thomas Warner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>APR 27 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

VR A15 (4)  
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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DEPARTMENT OF HEALTH

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05729

05729

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington D.C.</b> b. COUNTY <b>47.3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Andrew's Air Force Base Hospital</b>				d. STREET ADDRESS <b>1442 E Street, S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest</b>		First Middle Last <b>Toller</b>		4. DATE OF DEATH <b>4-7-67</b>		Month Day Year <b>19</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-12-14</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Leesville, Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>G. P. Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Toller</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>James Redd</b>		Address <b>5101 Fitch St SE Nash, DC</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>over 1 yr.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>		ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>4-8-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-12-67</b>		23b. DATE THEREOF <b>4-12-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family Plot</b>		23d. LOCATION (City or Town) (County) (State) <b>Leesville, Va.</b>	
24. FUNERAL DIRECTOR <b>Batney Funeral Home,</b>		ADDRESS <b>3831 9a, ave</b>		DATE <b>APR 11 1967</b>		REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05730

CERTIFICATE OF DEATH

05730

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN lb <u>16-1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>3900 Hamilton Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Pearl M. Tonis</u> First <u>PEARL</u> Middle <u>MARY</u> Last <u>TONIS</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>19 67</u>						
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-89</u>	9. AGE (In years last birthday) yrs. <u>78</u>	10. IF UNDER 1 YEAR Months <u>15</u> Days <u>19</u> Hours <u>67</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Samuel J. Calahan</u>			14. MOTHER'S MAIDEN NAME <u>Emma V. Long</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital admission record</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GEN. ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>17 DAYS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>67</u> , to <u>4-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-14</u> , 19 <u>67</u> , and that death occurred at <u>3:15</u> A.M., from causes and on the date stated above.								
22a. SIGNATURE <u>C. J. Houmann</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-15-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>		22d. ADDRESS <u>RIVERDALE MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>APRIL 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD.</u>		
24. FUNERAL DIRECTOR <u>W. W. Chambers &amp; Sons, Riverdale, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05731

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05731

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		d. STREET ADDRESS <b>5118 Kenilworth Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>DENNIS</b> First <b>EVERETT</b> Middle <b>TREVETT</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1959</b>
9. AGE (In years last birthday) yrs. <b>8</b>		IF UNDER 1 YEAR Months <b>16</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Donald E. Trevett</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia E. Groff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Donald E. Trevett Same as #2 (father)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Congenital heart disease</b> (b) <b>(tetralogy of fallot)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>4-24-67</b>	
ACTUAL SIGNATURE <b>John Kehoe</b> M.D. EXAMINER'S NAME (Type) <b>John Kehoe, M. D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/28/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Adams N. Y.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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05732

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05732

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>31 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>5312 Pontiac Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sophie Katherine Triesler</b>		4. DATE OF DEATH Month Day Year <b>4 29 1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-28-1872</b>
9. AGE (In years last birthday) <b>95</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Stuttgart Germany</b>
13. FATHER'S NAME <b>(unknown) Wager</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Adolph W. Triesler 5912 Pontiac St</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>4/200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Intertrochanteric fracture of right hip</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>fell at nursing home (Magnolia Gardens)</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fell at nursing home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. m. <b>6:00pm 3-29 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>nursing home</b>		20f. (City or town) (County) (State) <b>Lanham P.G. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>4-30-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Md.</b>		23. NAME OF CEMETERY OR CREMATORY <b>Hausoleum Rose Hill Cem Hagerstown Wash Co Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/2/67</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25. REC'D BY REGISTRAR <b>MAY 3 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

05733

0573

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <b>PRINCE George</b>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residing before admission) b. COUNTY <b>MARYLAND</b>	3. DATE OF DEATH Month <b>APRIL</b>	4. DATE OF DEATH Day <b>3</b>	5. DATE OF DEATH Year <b>1967</b>	
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYGASHVILLE</b>	c. LENGTH OF STAY IN 1b <b>2 YRS. 8 days.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>	d. STREET ADDRESS <b>1942 400 PLACE S.E.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CARROLL MANOR.</b>	First <b>ARTHUR</b>	Middle <b>DOMINIC</b>	Last <b>UNDERWOOD</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CREDIT DEPT.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>WASH. GAS. Light.</b>
	5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 30, 1893</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>1</b> Min.
	11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>BENJAMIN Underwood</b>	14. MOTHER'S MAIDEN NAME <b>MARY Foley</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>579-03-2005</b>
	17. INFORMANT <b>Helen Underwood</b>	Address <b>1942 400 Place S.E. Wash. D.C.</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO (b) <b>CEREBRAL VASCULAR INSUFF</b> DUE TO (c) <b>GENERALIZED ATHEROSCLEROSIS</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS.</b> <b>YRS.</b>		
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>POST RESECTION CR OF TONSIL &amp; MELANOMA.</b>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from <b>November 28, 1965</b> , to <b>April 3, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>March 28, 1967</b> , and that death occurred at <b>12 M.</b> from the causes and on the date stated above.	22a. SIGNATURE <b>Harold W. Draper</b> M.D.	22b. DATE SIGNED <b>4/3/67</b>	22c. PHYSICIAN'S NAME (Type) <b>HAROLD W. DRAPER M.D.</b>
	22d. ADDRESS <b>911 SILVER SPRING AVE SPRING</b>	23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-7-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oceday Hill</b>	23d. LOCATION (City, town or county) (State) <b>Smithland, Md</b>	24. FUNERAL DIRECTOR'S SIGNATURE <b>Matthew 131-11th St. S.E. D.C.</b>
	25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61



0233



05734

CERTIFICATE OF DEATH

05734

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1 hr. 25 mins</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>						d. STREET ADDRESS <b>P. O. #64</b>					
3. NAME OF DECEASED (Type or print) First <b>Ellwood</b> Middle <b>G.</b> Last <b>Valentine</b>						4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/8/08</b>		9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Yellow Cab</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Elwood G. Valentine Sr.</b>						14. MOTHER'S MAIDEN NAME <b>Cecelia</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-22-9515</b>		17. INFORMANT <b>Gertrude A. Valentine</b> Address <b>Same As # 2</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema &amp; Cardiac Arrest</b> DUE TO (b) <b>Probably coronary artery disease</b> DUE TO (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>April 14, 1967</b> , to <b>April 14, 1967</b> , that <del>we</del> (we) last saw the deceased alive on <b>April 14, 1967</b> , and that death occurred at <b>8:40 M.</b> from causes and on the date stated above.											
22a. SIGNATURE <b>Edwin J. Jensen</b>						M.O. ATTENDING PHYS. <input type="checkbox"/> MED. AM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 14, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Elwin J. Jensen, M.D.</b>						22d. ADDRESS <b>Prince Georges General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/17/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland Prince Geo. Md.</b>		
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc. 517 11th St S.E. Wash. D.C.</b>						25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05734

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05735

05735

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET <b>5019 Gerinomo Street</b>	
3. NAME OF DECEASED (Type or print) <b>Violet M. Vanagas</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Oct., 1907</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>John William MacKenzie</b>		14. MOTHER'S MAIDEN NAME <b>Francis Elizabeth Stiger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>067 16 1652</b>	
17. INFORMANT <b>George Vanagas Same as #2 Son</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarct</b> DUE TO <b>cardiac arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , 19 <b>11/29</b> , to <b>11/29</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11/29/67</b> , and that death occurred at <b>5:10 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Leon Levitsky</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Leon Levitsky, M.D.</b>		22d. ADDRESS <b>3408 R. I. Ave. Mt. Rainier, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/2/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05330

05330

CERTIFICATE OF DEATH

State of New York, County of New York, City of New York.

I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 10th day of January, 1907, at New York, New York, died

of the disease of

at the residence of

New York, New York.

Witness my hand and seal this 10th day of January, 1907.

Signature of Physician

Signature of Deceased

1907, Jan 10, at New York, New York.

Signature of Physician

Signature of Deceased



FOR STATE  
HEALTH DEPT

05736

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05736

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5264 Marlboro Pike</b>	
3. NAME OF DECEASED (Type or print) <b>Mark Anthony Vidotto</b>		4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 Feb. 1962</b>
9. AGE (In years lost birthday) yrs. <b>5</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Mario Vidotto</b>		14. MOTHER'S MAIDEN NAME <b>Alice V. Robertson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mario Vidotto</b>		Address <b>Same as Item No. 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemo-peritoneum</b> <b>8124</b> DUE TO <b>Laceration of liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>From trauma -</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by truck.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>2:00pm 4-16-1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5200 Block Marlboro Pike, Prince Geo. Co. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>4-17-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr. 20-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, DC</b>
24. FUNERAL DIRECTOR <b>Simmons Bros</b>		25a. REC'D BY REGISTRAR <b>APR 19 1967</b>	
Address <b>1661-Good Hope Rd SE Wash DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05737

CERTIFICATE OF DEATH

07172

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN lb <u>25 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Iceland Memorial Hospital</u>		d. STREET ADDRESS <u>315 Laurel Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>C.</u> Last <u>Vogts</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-81</u>
9. AGE (In years lost birthday) yrs. <u>85</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Beall</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth B urdette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Admitting record</u>	
17. INFORMANT <u>Admitting record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> DUE TO (b) <u>ATRIAL? TACHYCARDIA</u> DUE TO (c) <u>4331</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u> <u>ONE DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>67</u> , to <u>4-28</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>4-28</u> , 19 <u>67</u> , and that death occurred at <u>10:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C.J. Houmann</u>		22b. DATE SIGNED <u>4-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.J. HOUMANN</u>		22d. ADDRESS <u>RIVERDALE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-1-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Laurel PG Md</u>	
24. FUNERAL DIRECTOR <u>Paul H. Houdon</u>		25a. REC'D BY REGISTRAR <u>MAY 9 1967</u>	
ADDRESS <u>Laurel Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



7/3/74  
11:10

1871

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR, FBI

SUBJECT: [Illegible]

DATE: 7/3/74

TIME: 11:10

FROM: [Illegible]

TO: [Illegible]

RE: [Illegible]

[Illegible handwritten notes and stamps follow, including a large circular stamp with the number 100 and a date stamp 7/4/74]



05738

CERTIFICATE OF DEATH

05737

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>15 hrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights</b>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>1010 59th Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Wallace</b> Last <b>Wallace</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>13 May 1930</b>
9. AGE (In years last birthday) yrs. <b>36</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Worked</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Florine Tolliver Samuels 2D</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Rosie Butler</b>		Address <b>5554 B St S.E. DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe pulmonary edema, bilateral</b> DUE TO (b) <b>Pneumonia, bil.</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>April 8,</b> 19 <b>67</b> , to <b>April 9,</b> 19 <b>67</b> , that <del>we</del> (we) last saw the deceased alive on <b>April 9,</b> 19 <b>67</b> , and that death occurred <b>4:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>April 10, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>4-13-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland Rd Md</b>
24. FUNERAL DIRECTOR <b>H.S. Washington</b>		25a. REC'D BY REGISTRAR <b>ARR 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. H. Washington</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05737

Trinidad

Queverly

Trinidad General Hospital

Port of Spain

Tennis

10 May 1951

APR 11 1951



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05739

CERTIFICATE OF DEATH

05738

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>32 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>3400 Toledo Terr.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ozelle W. Waller</b>				4. DATE OF DEATH Month Day Year <b>April 2 19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12 Nov., 1910</b>	9. AGE (In years last birthday) <b>56</b> yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inf. Spec.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Dept. Of Aug.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S. A.</b>	
13. FATHER'S NAME <b>Robert W. Waller</b>				14. MOTHER'S MAIDEN NAME <b>Ada N. Johnson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>457 74 2414</b>		17. INFORMANT Address <b>Mrs. Gertie A. Alford Ft. Worth, Texas</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150X Squamous cell Ca of esophagus</b> DUE TO (b) <b>Metastases to liver</b> DUE TO (c) <b>Recent partial esophagectomy, &amp; gastrojejunostomy</b> <b>preparation of gastroesophageal site &amp; anastomosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-3-1967</b> , to <b>4-2-1967</b> that (I) <del>last</del> saw the deceased alive on <b>4-1-1967</b> , and that death occurred <b>12:30AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>A Deitz</b>				22b. DATE SIGNED <b>4/2/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M.D.</b>	
22d. ADDRESS <b>Prince George Plaza, Hyattsville, Md.</b>							
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kappernal</b>		23d. LOCATION (City or Town) (County) (State) <b>Keppernal Texas</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Francis Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05738

05738

Princeton, New Jersey

Princeton, New Jersey

Princeton, New Jersey

32 days

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05740

## CERTIFICATE OF DEATH

05739

1. PLACE OF DEATH a. COUNTY <b>Prince George's m</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>8 hrs.17 min.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>		16/	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4916 Deal Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Wayman</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/6/67</b>
9. AGE (In years lost birthday) yrs. <b>16</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Hall Wayman</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn Lillian Heiss</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give <u>war</u> or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mother</b>		Address <b>As above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATELECTASIS, PUL, PULMONARY</b> DUE TO (b) <b>PREMATURITY (700 Grams)</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 6</b> , 1967, to <b>April 6</b> , 1967, that (I) (we) last saw the deceased alive on <b>April 6</b> , 1967, and that death occurred at <b>11 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Bernardo Alvarado, M.D.</b>		22b. DATE SIGNED <b>4/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M.D.</b>		22d. ADDRESS <b>6201 Riverdale Rd., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>4/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hosp. Cheverly PG Maryland</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Admin., Cheverly, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05133

05133

STATE OF OHIO

IN SENATE,  
January 1, 1907.  
REPORT  
OF THE  
COMMISSIONER OF THE  
BUREAU OF REVENUE,  
FOR THE YEAR  
ENDING DECEMBER 31, 1906.  
COLUMBUS:  
THE STATE BOOK CONCERN,  
1907.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (15)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05741

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05740

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>3617 65th. Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harold Leroy Weaver</b>				4. DATE OF DEATH Month <b>4-</b> Day <b>28</b> Year <b>19 67</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 Feb. 1914</b>	9. AGE (In years last birthday) <b>53</b> yrs.	10. UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TEL-ADDS</b>		11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>ERNEST J. WEAVER</b>				14. MOTHER'S MAIDEN NAME <b>MINNIE MORDORS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>578-01-4928</b>		17. INFORMANT <b>MRS VIRGINIA C. WEAVER</b>		Address <b>442 Kennedy Dr. McLean, Va</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 14 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>4-28-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/1/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT LINCOLN</b>		23d. LOCATION (City or town) (County) (State) <b>Prince Geo. Co. MD.</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. St. Spurhead</b>				25a. REC'D BY REGISTRAR <b>MAY 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



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Lawrence

Prince George's

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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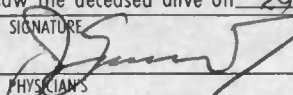

VR A15 (4)  
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05742

CERTIFICATE OF DEATH

05741

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEVERNA PARK</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		d. STREET ADDRESS <b>305 ST IVES ST</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>FRANKLIN</b> Last <b>WHISENAND</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>29</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 9, 1911</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USAF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USAF</b>	11. BIRTHPLACE (County & State, or foreign country) <b>BROWN CO. INDIANA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WALTER W WHISENAND</b>	
14. MOTHER'S MAIDEN NAME <b>MARY KATHERINE LIPPS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>	
16. SOCIAL SECURITY NO. <b>557 05 1732</b>		17. INFORMANT <b>WIFE</b> Address <b>SAME AS 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>27 APRIL, 19 67</b> , to <b>29 APRIL, 19 67</b> , that (I) (we) last saw the deceased alive on <b>29 APRIL, 19 67</b> , and that death occurred at <b>3:30 AM</b> , from causes on and on the date stated above.	
22a. SIGNATURE 		22b. DATE SIGNED <b>29 APRIL 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN SIMONATIS, MAJ, USAF MC</b>		22d. ADDRESS <b>USAF HOSP ANDREWS AFB 20331</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/3/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>
23d. LOCATION (City or Town) (County) (State) <b>Fort Myer, Virginia</b>		24. FUNERAL DIRECTOR <b>The Demaine Funeral Homes, Inc., Alexandria, Va.</b>	
25a. REC'D BY REGISTRAR <b>DATE MAY 2 1967</b>		25b. REGISTRAR'S SIGNATURE 	



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05743

STATEMENT OF DEBIT

DATE OF DEBIT

AIRLINE FOR

2 DAYS

EXCHANGE RATE

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STATE OF NEW YORK

DATE

STATEMENT

STATEMENT OF DEBIT

DATE

STATE

STATE OF NEW YORK

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MAY 2 1961



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

05743

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05742

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>Oakland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pr. Geo. Gen. Hosp.</b>		d. STREET ADDRESS <b>5505 Walker Mill Road</b>	
3. NAME OF DECEASED (Type or print) <b>SYDNEY MUDD WILDMAN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1915</b>
9. AGE (In years birthday) yrs. <b>52</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bldg. Const.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas H. Wildman</b>		14. MOTHER'S MAIDEN NAME <b>Lita Sheppard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>579 10 4430</b>	
17. INFORMANT <b>Dorothy G. Wildman</b>		Address <b>Wife Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Wildman Sub Sural</b> DUE TO <b>Hematoma</b> DUE TO <b>Locusts of Bru</b> 2 days		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident fell from a car</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <b>4-7-67</b>		23. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 10, 1967</b>	
23c. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>		24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05744

Item #11 infor, taken from birth cert.

## CERTIFICATE OF DEATH

Item # 3, infor. taken from birth cert.

05743

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>2hrs. 41mins</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>2117 Guilford Rd.; Apt. 301</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Christine Baby Lynn Williams</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1967</b>
9. AGE (In years last birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>41</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cheverly, Pr. Geo. Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Norman Allen Divver</b>		14. MOTHER'S MAIDEN NAME <b>Mary Veronica Gorman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Erythroblastosis fetalis due to Rh incompatibility</b> 7700 DUE TO (b) <b>to Rh incompatibility</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>Dr. Bernardo</b> (this hospital) attended the deceased from <b>April 18, 1967</b> , to <b>April 18, 1967</b> , that <b>(x)</b> (we) last saw the deceased alive on <b>April 18, 1967</b> , and that death occurred on <b>April 18, 1967</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Bernardo, Alvarado, M.D.</b>		22b. DATE SIGNED <b>April 20, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bernardo, Alvarado, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>4/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hosp.</b>	23d. LOCATION (City or Town) (County) (State) <b>Cheverly PG Maryland</b>
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Admin.</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>	
c. LENGTH OF STAY IN 1b <b>53 hrs</b>		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Box 175, Rt. 2</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Parker J Windsor</b>		4. DATE OF DEATH Month Day Year <b>4 3 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 March 1921</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>46</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pence Installer Retail</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
11. BIRTHPLACE (State or foreign country) <b>Piscataway, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy Windsor</b>		14. MOTHER'S MAIDEN NAME <b>Edith Tayman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO. <b>218-16-0486</b>	
17. INFORMANT <b>Mrs. Edith Windsor</b>		Address <b>Rt. 2, Br. 175 Brandywine Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9369 IMMEDIATE CAUSE (a) <b>Sub-dural hematoma</b> DUE TO <b>And infarct of brain stem</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Unknown</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>unknown m. unknown 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>unknown</b>		20f. (City or town) (County) (State) <b>unknown</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		M.D. <b>John Kehoe, M.D. Riverdale, Md.</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		22. DATE SIGNED <b>4-4-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-7-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Piscataway Prince Geo, Md.</b>	
24. FUNERAL DIRECTOR <b>The Hunt Funeral Home, Waldorf, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
ADDRESS <b>The Hunt Funeral Home, Waldorf, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05746

# CERTIFICATE OF DEATH

05745

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>District of Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS NURSING HOME</u>		d. STREET ADDRESS <u>639 Jefferson Street N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>MATTIE PEARL WOODARD</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/14/1895</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Duty</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Luray Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank Shenk</u>		14. MOTHER'S MAIDEN NAME <u>Unknown at this time</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mr. Amos Burke</u>		Address <u>639 Jefferson St. N.E.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Arteriosclerotic Heart Disease</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>7:00</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>  </u>		22d. ADDRESS <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beaumont Chapel Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Luray Virginia</u>
24. FUNERAL DIRECTOR <u>W. K. Huntemann &amp; Son</u>		25a. REC'D BY REGISTRAR <u>APR 28 1967</u>	
ADDRESS <u>5732 Georgia Ave N.W.</u> <u>Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



05745

RECORDS OF LABOR

05745





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05747

## CERTIFICATE OF DEATH

05746

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>	
d. STREET ADDRESS <b>Box 2352</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cecelia</b> Middle <b>E.</b> Last <b>Yarbrough</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/95</b>
9. AGE (In years last birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>578X</b> IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> DUE TO (b) <b>Severe anemia</b> DUE TO (c) <b>G I bleeding</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan.</b> , 19 <b>67</b> , to <b>Apr</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/13</b> , 19 <b>67</b> and that death occurred at <b>2:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. Clark Holmes</b>		22b. DATE SIGNED <b>4/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M. D.</b>		22d. ADDRESS <b>4108 Pratt St., Upper Marlboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Johns Hopkins School of Med. Baltimore, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR		ADDRESS	
25a. REC'D BY REGISTRAR DATE <b>APR 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



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W. A. Gillette, M. D.



## CERTIFICATE OF DEATH

05748

05748

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Bowie</b> d. STREET ADDRESS <b>Tanglewood, Zug Road 521.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marjorie Zug</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/31/76</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years lost birthday) yrs. <b>90</b>
10a. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D.C.</b>	
13. FATHER'S NAME <b>John Edgar Zug</b>		14. MOTHER'S MAIDEN NAME <b>Frances Ege</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215 54 4718</b>	
17. INFORMANT <b>Frances Ann Zug Stokes</b>		18. ADDRESS <b>6112 Bellinhan Ct. Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sarbo enteritis acute</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>60</b> , to <b>April 18, 1967</b> , that (I) (we) lost saw the deceased alive on <b>April 18, 1967</b> , and that death occurred at <b>7:45 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert S. McCeney</b>		22b. DATE SIGNED <b>April 18, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert S. McCeney, M.D.</b>		22d. ADDRESS <b>402 Main Street, Laurel, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Church</b>	23d. LOCATION (City or Town) (County) (State) <b>Collington P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



